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**ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.**

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence
for
August 31, 1983

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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN
AND RELATED MATTERS.

Hearing held on the 8th Floor,
180 Dundas Street West, Toronto,
Ontario, on Wednesday, the 31st
day of August, 1983.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
THOMAS MILLAR - Administrator
MURRAY R. ELLIOT - Registrar

APPEARANCES:

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E. CRONK)	
T.C. MARSHALL, Q.C.	Counsel for the Attorney- General and Solicitor General of Ontario (Crown Attorneys and Coroner's Office)
I.G. SCOTT, Q.C.)	Counsel for The Hospital
R. BATTY)	for Sick Children
M. THOMSON)	
B. PERCIVAL, Q.C.)	Counsel for The Metropolitan
D. YOUNG)	Toronto Police
W.N. ORTVED	Counsel for numerous Doctors at The Hospital for Sick Children
E. SYMES	Counsel for the Registered Nurses' Association of Ontario and 35 Registered Nurses at The Hospital for Sick Children

(Cont'd)



APPEARANCES: (Continued)

D. BROWN	Counsel for Susan Nelles - Nurse
E. FORSTER	Counsel for Phyllis Trayner - Nurse
C. BUHR	Counsel for Sui Scott - Nurse
B. KNAZAN	Counsel for Mrs. M. Christie - R.N.A.
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes and Mr. & Mrs. Murphy (parents of deceased children)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines, (parents of deceased child Jordan Hines)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
J. SHINEHOFT	Acting for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)



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BB/cr

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2 ---Upon commencing at 10:00 a.m.

3 THE COMMISSIONER: This is a public
4 inquiry and since its inception I have tried to keep
5 it public and to conduct as little business as possible
6 behind closed doors. However, as in all public
7 inquiries as in all public trials there have been times
8 when it seemed appropriate to discuss with counsel
9 certain matters in private. One of those matters in
10 this Inquiry has been the funding of parties and the
11 fees their counsel will be entitled to charge against
12 the public purse. It may be that in due course the
13 amount of counsel's fees will become a public issue,
14 particularly if the issue is raised by counsel them-
15 selves. In the discussion stages, however, more for
16 the sake of counsel than for anyone else, I thought
17 that it would be best to keep the discussion
18 private.

19 The attainment of a reasonable fee for
20 services rendered is a perfectly legitimate aim but
21 I firmly believe that some of the bills submitted by
22 counsel are not reasonable. It is my responsibility
23 to approve all those accounts and so it was obviously
24 necessary for me to express my concern to counsel and
25 to discuss the problem with them. For that purpose
on Wednesday last after the close of the hearing for



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2 the day I held a meeting with funded counsel
3 specifically to discuss their projected fees for
4 the duration of the Commission and the accounts that
5 had been submitted to date. The meeting was declared
6 to be a private one. The door of the meeting place
7 was closed and no one other than funded counsel and
8 some Commission staff and I were present. I was more
9 than a little distressed to read in Friday's Globe
10 and Mail an article disclosing the subject matter
11 discussed at that meeting together with one counsel's
12 viewpoint on the matter. I attached no blame to the
13 newspaper which obviously considered the story to be
14 worth printing and had obviously received the story
15 from someone in attendance at the meeting. The
16 article accurately reflected the subject matter and
17 the mood of at least some of the counsel present.

18 What does concern me is that counsel should reveal
19 to the press what was discussed at that private meeting
20 without reference to me or I assume to anyone else.
21 The disclosure appears to have been selective. Nothing was
22 disclosed of the amount of the bills submitted or of
23 my suggested limits upon monthly accounts. I do not
24 see how any counsel can maintain that his clients are
25 being deprived of fair representation without at the
same time revealing what he is claiming for compensation



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2 and what I am proposing instead. I wish to emphasize,
3 however, that I consider any disclosure in the
4 circumstances to have been improper. Put very simply,
5 when I have a private meeting with counsel I do not
6 expect to read about it the next day in the newspapers.

7 I consider what took place a breach
8 of confidence and I was and remain shocked and deeply
9 offended that it could have happened. Perhaps my
10 sense of the standard of propriety required of counsel
11 is no longer in some quarters fashionable but it is
12 a standard firmly held by me for many years. I do
13 not intend to depart from that standard or permit
14 anyone appearing at this Inquiry to depart from it.

15 As has been noted, I have been reluctant
16 to make rulings in this Commission but I make one now.
17 I shall not in future have any private meetings with
18 any counsel unless there is complete trust that the
19 privacy of those meetings will be respected and
20 honoured.

21 That is all I have to say. If anyone
22 wants to say anything on the subject I will certainly
23 hear him, otherwise, Mr. Olah, I think we will continue
24 with the cross-examination.
25



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2 DR. RICHARD DESMOND ROWE, Resumed

3 CROSS-EXAMINATION BY MR. OLAH: (Continued)

4 Q. Doctor, just a couple of short
5 matters I would like to clarify further with you if
6 I could.

7 You have talked about the establishment
8 of an intermediate ICU unit on the Wards 4A and 4B
9 in November of 1982. As I understand it, the tenor
10 of the meetings in December, the correspondence between
11 you and the Surgery Department and the tenor of the
12 meeting of January, the mortality conference review
13 was the need for an intermediate ICU and it in effect
14 came into being in November of 1982?

15 A. Yes.

16 Q. The question I have is, you are
17 familiar with the Children's Hospital in Boston,
18 I understand?

19 A. Yes.

20 Q. Is there such an intermediate
21 ICU unit on the cardiology wards at the Children's
22 Hospital in Boston?

23 A. I'm not sure whether they have
24 one now but I don't think they had one when I was
25 there, when I visited them at any rate.



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Q. During the time period that we are talking about, that is July of 1980 to March 31st, 1981, was there such a unit in existence in Boston?

A. I'm not aware of one if there was but I haven't made specific enquiries.

Q. Similarly, the other major children's hospitals in Texas, as I understand it, Houston?

A. Yes.

Q. Was there a cardiology intermediate ICU unit there during this period of time that we are discussing?

A. I don't know whether there was or not and at the time I visited them some years before there wasn't.

Q. Is there one there at the present?

A. I don't know.

Q. That kind of intermediate setting, is that normal in children's hospitals today?

A. Well, some areas in the hospital, in our hospital have an intermediate type setting like that. I believe in the Ear, Nose and Throat Department there is an intermediate type of



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care unit.

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Q. I am more concerned about cardiology wards though and in your hospital at the present time. Do you know of any other hospital that has such an intermediate unit?

A. No, there aren't very many hospitals that have the size of operation that we have there, so, there might be other reasons why they don't.

Q. So, I take it the answer is no?

A. Yes.

Q. Thank you. Now, in completing our discussion I would like to clarify one further matter that has been troubling me. You talked about your impression that there was a cluster of young children and a cluster of children with much graver symptoms or cardiac situations than you had experienced in the past and that was the explanation as far as you could tell for the increased level of deaths on Wards 4A and 4B?

A. That's what we thought.

Q. And in fact I understand that your impression has been borne out. You have had a chance to review the Atlanta Report?

A. Yes.



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Q. And in fact that impression was verified by the report, as I understand?

A. I believe it is.

Q. The matter that puzzled me to some extent was this. You indicated that you were aware in January some time of the fact that a very large number of the deaths were occurring between, I believe zero hours and six o'clock in the morning. Do you remember giving that evidence?

A. Yes.

Q. And I think it was your further evidence that you were not aware at that time of the study I think that was conducted at McMaster which seemed to confirm empirically that impression?

A. That's correct.

Q. Now, I take it that your own impressions were formed on the basis of experience you had on the Cardiology Wards 4A and 4B and previously Ward 5?

A. And in other institutions as well.

Q. Now, I was wondering if I could have Exhibit 35 for a moment, please, Mr. Registrar. Do you have a copy of Exhibit 35, Doctor. That is the On-Wards Deaths by Time?



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A. No, I don't.

Q. Now, I am just somewhat puzzled. I noticed Exhibit 35 covers five different time frames each having a period equivalent of about nine months.

THE COMMISSIONER: I'm sorry, Mr. Olah, there are - Exhibit 35, the first one covers six different time frames.

MR. OLAH: I'm sorry, Mr. Commissioner.

THE COMMISSIONER: The one I am looking at covers six different time frames.

MR. OLAH: It is entitled On-Ward Death by Time, each period equals nine months.

THE COMMISSIONER: Perhaps I am wrong.

MR. OLAH: Yes you are correct, I am in error and I apologize. There are six time periods there.

Q. Do you see that, Doctor?

A. Yes.

Q. And you will notice that those time periods, and this is where the confusion arises, are broken down according to time frames, that is, nine month periods for each of the time periods outlined on Exhibit 35?

A. Yes.



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Q. And I take it the black line in the very first column is, as I recall it, the very first period that this chart denotes?

A. Yes.

Q. And that represents a number of deaths between 1:01 and 5 o'clock in the morning?

A. Yes.

Q. I notice that it is about the same level as is 1301 to 17 hours?

A. Yes.

Q. And also about the same level as 1701 to 2100 hours?

A. Yes.

Q. And similarly very identical to the time period between 2101 and 1 o'clock in the morning?

A. Right.

Q. And if I were to carry that out selectively with all of the time frames other than the period under enquiry you get similar results?

A. Yes.

Q. Would you agree with me, Doctor, that your own statistics don't seem to bear out that impression that you conveyed?

A. Well, I think I have said before,



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2 that I don't dispute these figures, of course they
3 are figures that have been collected and put in, but
4 I think that this whole area is one where it is easy
5 to take a simplistic view of the time periods and
6 to say that this is different from that. But I
7 think you need epidemiologic analysis of this sort
8 of data and I believe that in some preliminary
9 assessments of the time periods involved using night
shift versus day shift ---

10 Q. We're now talking 7:30 in the
11 evening to 7:30 in the morning?

12 A. Yes, yes. If you use night
13 shift versus day shift, which is the way most people
14 look at the hospital issues in terms of time, that
15 there are huge discrepancies between the pre-epidemic
16 period, the epidemic period and the post epidemic
17 period, particularly in the post epidemic period only
18 something like 10 per cent of the babies died at
19 night. In the pre-epidemic period about half of them
20 died at night and in the epidemic period 90 per cent,
21 or whatever it is died at night. So there are a whole lot of
22 factors that can influence those figures. There is
23 nothing wrong with the figures, it is simply the
24 interpretation of that data that becomes difficult
25 and I think needs the expertise of an epidemiologist



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2 because there are factors that can influence it
3 besides the things that you appear to see.

4 Q. All right. Well, just going
5 back to what we were discussing a moment ago. So,
6 you are in agreement that certainly this analysis
7 doesn't seem to coincide with your impression, Exhibit
8 35?

9 A. I think it agrees with my
10 impression in that there is a period where the peak
11 of deaths occurred and that the other periods may
12 depend on a whole lot of things, such as, the age of
13 the patients coming in, a whole lot of interventions
14 that may have been made after the epidemic period and
15 so on.

16 Q. Oh, I understand that. But
17 we are talking about deaths at certain hours and what
18 I don't understand is, assuming that this chart is
19 correct, there seems to be no real major departure in
20 terms pre-epidemic and post-epidemic in terms of deaths
21 during those hours?

22 A. That's correct.

23 Q. All right. And your own rough
24 guideline was that pre-epidemic it was about 50
25 per cent and post-epidemic it was about 10 per cent
during the night shift?



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A. Yes, something like that.

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Q. And yet during the epidemic period you had something like in the order of about 90 per cent?

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A. Yes.

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Q. Now, one further thing that puzzles me is this. Is there some sort of a rough guideline as to the kind of expectations or correlations in deaths you expect between deaths in the OR, deaths on ICU and deaths on Wards. Is there some ratio that generally exists or you expect to exist?

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A. Well, I'm not sure you can ever make that sort of comparison other than in very broad terms because it depends on the population you are dealing with at the time.

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Q. Well, let me ask you this question. Would you expect deaths on the ward to be less than, say, combined OR and ICU?

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A. Yes, I think you would. Optimally you would.

21

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Q. Well, normally you would, would you not?

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A. Optimally you would.

Q. Is there a difference between



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my use of the word "normally" and yours "optimally"?

3

A. Well, I am looking at it

4

from the optimal point of view.

5

Q. All right.

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THE COMMISSIONER: I'm sorry, you would expect optimally speaking, you would expect what, the ward deaths to be lower?

7

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THE WITNESS: Lower than the intensive care and operating room.

9

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MR. OLAH: Q. Well, in fact, Doctor,

11

is that generally the case in ~~the cardiology~~ section or the Cardiology Department?

12

A. It has been.

13

14

THE COMMISSIONER: Just so I can get it straight. You would expect them to be less than they are in the OR and the ICU combined?

15

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THE WITNESS: Yes, yes.

17

THE COMMISSIONER: In either, less than the ward?

18

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THE WITNESS: He asked me if they would be combined, Mr. Commissioner, and I said yes.

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THE COMMISSIONER: Could you answer it the other way too, would you expect there to be less than there were in the OR or less than in the ICU or just less than the combination?

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2 THE WITNESS: Less than the combination
3 I expect, or either if you wish that.

4 THE COMMISSIONER: Well, I just wish
5 you would tell me which you would expect.

6 THE WITNESS: No, if you wish me to
7 state it in those terms I can, yes.

8 MR. OLAH: Well, I'm sorry, I admit
9 now I am confused. Would you expect the number of
10 deaths on the wards to be combined Wards 4A and B to
11 be less than the number of deaths for example on ICU?

12 THE WITNESS: Yes I would, normally.

13 Q. Normally?

14 A. Optimally, let me put it that
15 way.

16 Q. All right. Well, let's use
17 normally, generally, has that been the experience in
18 the hospital?

19 A. Yes, I think it has.

20 Q. What about the relationship
21 in the number of deaths between the operating room
22 and the Wards A and B?

23 A. Higher in the operating room
24 I think.

25 Q. Higher in the operating room.
Now, as I recall, you prepared a summary some time in



1 late December of 1980 or January of 1981 in which you
2 compared those figures, did you not, Doctor?

3 A. Yes, I think I did.

4 Q. And is my recollection correct
5 that you had something in the order of 12 deaths on
6 the ICU and 4 deaths in the operating room between
7 July 1st and December 31st, 1980?

8 A. I can give you those figures
9 precisely if you will allow me time. Between July
10 and ...?

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Q. I am sorry. It was eleven
and five. I think if you look at Exhibit 65 and 65A,
that may assist you.

Do you have Exhibit 65A before you,
doctor?

A. I have Exhibit 65A there, but
you recall I made some corrections.

Q. Yes. I believe the correction
was to reduce the number of deaths on the ward from
22 to 20, was it not?

A. Yes. But in relation to the
'other' deaths. Deaths on the ICU, I think I changed
some figures there. It is hard to say because they
were not terribly accurate.

Q. All right.

A. I can give you more complete
figures from July 1st to March, if you like, for the
OR and ICU. Would that be helpful?

Q. I would like to deal with
Exhibit 65A. I'm sorry, I don't recall your evidence
as to the corrections precisely. Can you assist me
in that regard?

A. Well, I don't seem to have
the sheet that gives me the question about the
operating room.



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Q. Would you agree with me that roughly the number of deaths, combined deaths in the OR and the ICU were in the range of about 16 deaths for that timeframe?

A. I would have to check those figures. I'm afraid I can't remember that.

Q. Certainly, we are clear, are we not, doctor, that during that same timeframe the number of deaths on the ward was 20?

A. Yes.

Q. So that there was a departure, as I understand it, from the normal ratio that you had experienced in the past?

A. Yes, that is true.

MR. OLAH: Thank you very much, doctor. Those are all the questions I have.

THE COMMISSIONER: Thank you, Mr. Olah.

As I said yesterday, I have lost track - I don't know who has declined cross-examination and who has not.

Mr. Knazan, have you declined?

MR. KNAZAN: Miss Jackman has already cross-examined.

THE COMMISSIONER: Yes, all right.



B3

Mr. Buhr.

MR. BUHR: I am delighted to decline.

THE COMMISSIONER: Yes, all right.

Then, I guess, unless I missed out on anyone, Mr. Shanahan, I think you are next. Are you?

MR. SCOTT: I know Dr. Rowe won't take these declinings as a sign of weakness!

CROSS-EXAMINATION BY MR. SHANAHAN:

Q. Doctor, I act for the parents of two families - Dawson and Lombardo - and I am going to confine my questions really essentially to that. I realize you have been on the stand a long time and I will try not to plough the same furrow over again.

Doctor, I am going to start, although second in time, with Baby Lombardo's death - I am going to deal with it first. Doctor, I am going to, just for a moment here, take you through briefly some aspects of the medical charts, the medical records, that have been filed as an exhibit already. I am going to go through briefly just some of the evidence you gave to Mr. Lamek and see if we can come to some conclusions and establish some common ground.

I refer you, first of all, sir, then to what I have marked as Exhibit 78, which would be the



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medical records of the child, Stephanie Lombardo.

Do you have that yet, doctor?

A. They are coming.

Q. Doctor, briefly, I have it
that this child was born December 13, 1983 at another
hospital - I'm sorry, 1980 - and is brought to the
Sick Children's Hospital that same day. On December
15th, she has the cardiac catheterization; it
reveals the defects that you have pointed out to us,
which, I believe, can fairly be summarized as
Tetralogy of Fallot --

A. Yes.

Q. -- and pulmonary stenosis.

A. Yes.

Q. And she survives, or she
tolerates the cardiac catheterization well and, on
December 17th, she has an operation, and that operation
is to put in a shunt.

A. Yes.

Q. She is in ICU for five days.
At the end of five days, on December 22nd, she is
moved, I think around midday, on to the ward.

A. Yes.

Q. And then, later that same
night, or more correctly into the early morning hours



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of December 23rd, she dies on the ward.

A. Yes.

Q. Sir, I have on the records here - and I think we can establish here that, although Baby Lombardo obviously had severe anatomical problems, she did, for all intents and purposes, seem to be progressing satisfactorily. In trying to establish that, sir, I start off at page 37 of the records, Lombardo's records, which is a note after she had completed the operation and had been admitted to the ICU.

Do you have page 37?

A. I have.

Q. At the top of that page, sir, it seems to indicate here - and I am translating a lot of the shorter forms, but it seems to indicate, after summarizing her, that she is:

"four-day old female, Tetralogy of Fallot. Had an operation to put in a shunt..."

And the comment after "intraop problems", I take it that means she had no particular problems with the operation itself?

A. No. No problems in her condition with the operation.



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Q. And further below, about
three or four lines:

"On admission intubated, breathing
on her own with assistance."

Coming down and in different hand-
writing, about two-thirds of the way down, there
appears to be another summary, and it is entitled
"ICU Nursing Admission note", and it concludes at
the end:

"Good A/E heard throughout. Chest
sounds clear."

"A/E" would be what, sir?

A. Air entry.

Q. And then, sir, at the very
bottom of the page, which seems to be in a Dr. Burn's
handwriting, could you read that for me. It is a
little unclear.

A. That is:

"Early systolic murmur. PO₂..."
That is the oxygen tension.

"...40-44. Seen by Dr. Izukawa,
who agrees..."
I'm sorry, it is not "early systolic murmur", it is
"only systolic murmur".

Q. All right.



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A. "...who agrees with the
murmur..."

I am not sure what the last part of
that is, something "today". I can't read it because
the first part is blotted out.

Q. Mine too.

Coming up then on page 38 --

A. I'm sorry. That does look
as though that is "parin", and that may be "heparin
today"

Q. Could that be "parents in
today"?

A. Pardon?

Q. Could it be "parents in today"?

A. No. That is an "r" before it.
It might mean "treatment, heparin today".

Q. She is eventually on heparin,
and we will get to that.

Following page 38, there is more ICU
progress notes. They same to be in different hand-
writing and the first line seems to comment that,
at 32:00 hours:

"She has been stable today."

And the very last line of that is:

"...plan start feeding as tolerated".



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Then we have what appears to be,
below that, an ICU note on December 19th by Dr.
Jedeikin.

A. Yes.

Q. If I can go through that. It
indicates:

"Heparin started..."

On line 3:

"...because murmur only systolic.

Stable in 40 per cent oxygen."

Am I right there? Am I reading
these short forms correctly?

A. Yes, 40 per cent.

Q. "PO₂ in the 40s. U.O. good."
What is "U.O."?

A. I don't know.

Q. Some comment is made, in any
event, that "U.O. is good".

A. I don't know what that is.

Q. All right.

"Colour is pink, dusky when cries.
No distress."

And dropping down again:

"Child's colour and PO₂..."

And I think that is an arrow meaning up?



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A. Yes.

Q. "...so one must assume
reasonable shunt function. Nutrition:
Starting on F.S.S.M.A. today."
I know S.M.A. is a children's
formula; is that correct?

A. Yes. And the "F.S." is full
strength, I would think.

Q. Fullstrength.
And dropping down to the bottom:
"Candidate for transfer to ward."
Is that correct?

A. Yes.

Q. Would "U.O." be "urinary
output"?

A. It may well be. I would have
to hire Mr. Lamek for that!

Q. Coming to page 40, sir, it
would be notes when she would be back on the ward.
There is handwriting - a distinctly different set of
handwriting about halfway down the page, and it starts
out with:

"Received patient from ICU at 11:50
hours."

So, she would be coming in from the



B10 1
2 ICU roughly in the late morning or around noon hour?
3 A. Yes.
4 Q. It indicates here, under
5 "colour", that she is:
6 "Colour - pink in 40 per cent O₂. No
7 change in colour when out of O₂. O₂
8 now discontinued."
9 That would again be indicative
10 here - there is no adjective here saying "good" or
11 anything of that nature?
12 A. No.
13 Q. But as I, with a little bit
14 of experience we have gained with these records, it
15 would appear to me, doctor, that would be a good sign;
16 interpreted as a good sign?
17 A. Yes.
18 Q. Another one here, coming down
19 two lines below - I can't see the first word; it may
20 well be "chest", but the line is clear. It is:
21 "Air entry throughout, noisy upper
22 lobes. Nutrition - taking formula
23 well. Output - voiding adequate
24 amount."
25 Down to the final comment:
"Parents both in today, held baby,



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fed baby, concerned. Asked lots of questions. Generally pleased with progress."

A. Yes.

Q. And they, being pleased with progress, would, I put to you, not only be from their observations as laymen of their child coming through the operation and coming through the ICU and now being on the ward, but I put to you, doctor, and it may be something you can't directly comment on, that the information they had been receiving, quite apart from their observations, was such as to make them feel that the child was doing all right?

A. Yes.

Q. And then, at page 41, sir, we have again, ironically out of sequence, we have at the top the terminal events ending in the child's death. Then, after the terminal events, the last nursing notes, and they really stand in stark contrast. I am going to deal with the last nursing notes, which are at the bottom, covering 19:00 to 03:30 hours. Again, the lower left-hand corner is slightly cut off for me, but I will do the best I can here. It seems to be:

"Patient relatively stable. Heparin



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infusing well. Patient feeding
eagerly..."

And it gives the amount of formula there.

"Apex 144-152 and regular. Respiration-
tions..."

I can't read the numbers.

"...shallow but in no distress.
Colour - pink..."

There seems to be then - I can't read the first few
words:

"...dusky when upset. Became restless
after second..."

And I'm guessing that it was maybe "feeding".

A. Yes.

Q. "...however, settled well."

A. Yes.

Q. And, then, final notes at

3:30 - that is the time that is written in the blank.
We have the onset of the terminal events, and those
last two lines really dovetail into the top part, and
that is:

"Became restless, breathing very
shallow. Apex irregular, bradycardia.
Placed on cardiac monitor..."

And away we go into the terminal events.



B13

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A. Yes.

Q. Doctor, I suggest to you that, in fact, number one, the very fact that this child would be considered a candidate for surgery, given the criteria that you have set out here and bearing in mind that the doctors, in general, did not wish to perform heroic surgery on children that were really beyond any salvation at all, the very fact that Stephanie Lombardo was taken in for treatment of her pulmonary stenosis and Tetralogy of Fallot, number one, is an indication the doctors felt they had a patient and a problem that they could work with?

A. Yes, indeed.



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Q. She tolerated that operation well and I think as you have said here today and has been said before that the first very high risk situation is the actual act of surgery itself, and she tolerated that well.

A. Yes.

Q. She moved into the ICU and would I suggest to you, Doctor, that her stay in the ICU of five days after an operation of that size and given the fact that she was at this point in time days old and I believe had been of low birth weight, that the stay of five days was really quite normal in the circumstances?

A. In the ICU?

Q. Yes.

A. No, I do not think so.

Q. Do you think it is long or short, sir?

A. The stay is relatively short, but I thought you said her stay was ---

Q. My question to you was that I think the duration of her stay five days, bearing in mind her age and the fact that she was a very small child and the operation that she had just undergone, that that five day stay was really quite



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normal. I do not characterize it as long or short.

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A. Yes.

4

Q. And then again it must be

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a sign of stability and some progress for that child,

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and I think the notes of Dr. Jedeikin point that out

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that child would then be moved from the ICU onto the

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ward, and that too would indicate to you, to the

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nurses and to the parents that she was progressing

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as you expected?

A. No, I think this is where I

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perhaps differ.

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Q. All right.

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A. You have not reviewed the

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note that is at the top of page 39, which is the note

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that I have placed a lot of stress on in previous

16

testimony, which is the note by Dr. Burns.

17

Q. Yes.

18

A. And that draws attention to

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the problem which is her concern as an intensivist

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and a pediatric cardiologist that despite the fact

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that the baby has been a little improved, that the

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degree of improvement is not sufficiently good to

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satisfy her. She is raising the question with

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Dr. Izukawa and Dr. Trusler about the need for a

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repeat shunt. Now, that is something that is not



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2 raised if babies are doing particularly well.

3 I think that was the point that I
4 think is key to this situation here. I think every-
5 thing you say about the appearances and so on in the
6 ward is correct. I would not dispute that. But
7 there is concern here about the size of the shunt.
8 It is a marginal shunt and that discussion was under-
9 taken, as I gather and as I have said before, the
10 view of Dr. Trusler was that the best expectation --
11 he did not think it would be possible to do another
12 shunt. Now, that was the verbal information that I
13 received, and he thought the best prospect for this
14 baby was to hang in there with heparin and try and
15 make sure that the shunt oriface remained open and
16 did not clot up.

17 I would remind you again that the
18 operation was an extremely unusual shunt. He could
19 not get any connection of the usual type between the
20 aorta and the pulmonary artery and he had to make
21 a small anastomosis between these two vessels them-
22 selves. The oriface size at the end of it was much
23 under what you would be able to get with a proper
24 gortex or other type of shunt. All I am saying is
25 that there was considerable concern in everybody's
minds about the possibility of the durability of that



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shunt being quite short.

Q. All right. You do not take issue, mind you, with the way we have gone through events here and things about her colour and feeding eagerly, she has got good ---

A. Not at all.

Q. But on page 39, I think it is point 4 is the one you followed up to discuss with Drs. Izukawa and Trusler the need for repeat shunt after PO₂ measured in RA, RA being ---

A. Room air.

Q. Room air, all right. And you characterized the operation that she had undergone as unusual?

A. Yes.

Q. And I think you said here, and I am referring here to the evidence you gave Mr. Lamek, and it would be at Volume 15 at page 2543, you described it much the same and I will just repeat it for you here. You said at line 17 that they faced a bit of a surgical dilemma when they actually opened her and saw that the arteries -- what they had to deal with?

A. Yes.

Q. And you said:



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2 "In the end the surgeon decided to
3 open the back end of the pulmonary
4 artery and try and make an incision
5 in the front end of the aorta and join
6 those two vessels together locally.
7 This is a procedure that they don't
8 particularly like to do if they can
9 avoid it, because it -- it at a high
10 risk of the anastomosed being
11 ineffective, but that was all that
12 could be done."

13 I appreciate the wording does not come through quite
14 as fluent.

15 A. Yes.

16 Q. And you characterized that as
17 unusual?

18 A. Yes.

19 Q. Well, sir, on page 75 of her
20 charts, that is of Exhibit 78 that you were first
21 given, there is an operative report there with
22 respect to what had been done for Stephanie Lombardo,
23 and under "operative procedure" on that page and I
24 will read it here -- have you located that page, sir?

25 A. Yes, I have.

Q. It says:



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"The patient was placed in the supine position, under general anesthesia, intubated, prepped and draped. The sternum was opened. The pericardium was opened also. The size of the main P.A. was 4 mms in diameter. The size was too small to work with a prosthetic graft as we had expected to do."

So that would seem to tie in with what you have said so far?

A. Yes.

Q. "So we decided to do a window between the ascending aorta and the P.A. We did it in the usual way, and the lumen of this window was 2.5 mms. We noticed an improvement in the systemic pO₂ rising from 27 to 47."

That improvement seems to have occurred almost immediately?

A. Yes.

Q. "Then the pericardium was closed and after careful hemostasis..."

If I have pronounced it right,

"...and inserting chest tubes in the



"anterior mediastinum and right chest,
the patient was closed in the usual
manner.

She was sent to the I.C.U. in good
hemodynamic status.

SUMMARY: A new born baby with
tetralogy of Fallot. She underwent
an arterial window between the ascend-
ing aorta and the main P.A. The
diameter of this window was between
2 and 2.5 mms. She underwent this
operation without problems."

Now, you have characterized it as unusual and twice
in that report it has really been characterized quite
the opposite. It has been characterized as usual.
I would submit to you that what the doctors were
presented with, Dr. Rowe, was not something they
had not seen before and that they responded on their
feet in there as they have described it in the usual
fashion?

A. I think your interpretation
of usual is one that we would not agree with because
I think that when people are writing a surgical note,
they are saying this is -- usual means the prescribed
way in which an anastomose of that sort might be



1
2 done, you know, the usual stitching and cutting and
3 that sort of thing. I do not think it is implied
4 that that is a usual procedure.

5 Q. You are saying it is a usual
6 response to an unusual problem?

7 A. Yes.

8 Q. All right. Finally,
9 Doctor, then in terms of what I saw as her stability,
10 that is that she was a candidate for the surgery,
11 tolerated the surgery, went through ICU in a reasonable
12 time, went on to the ward with all the comments that
13 we have seen, was the fact that this baby seems to
14 be, from the charts and the records that I have
15 looked at and prepared, she seems to be the first
16 child that we have looked at in this time period,
17 this epidemic period that has been on cardiac ward
18 for severe cardiac problems, she is the first child
19 that is not on and has not been prescribed digoxin.
20 That struck me again as indicative of the fact that
21 this child was not having the usual respiratory
22 and cardiac arrest or cardiac or congestive failure,
23 sorry, type of problems that required having digoxin
24 given to her at all?

25 A. No, she had a different sort
of malformation which seldom requires it.

Q. Well, sir, I thought



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2 that might be the response. Certainly many of the
3 children that we have seen have had pulmonary
4 stenosis and certainly many of them have had -- not
5 many, but some have certainly the other condition of
6 tetralogy of Fallot, and certainly they have, as I
7 look at their records and the names do not spring to
8 me right this minute, but they certainly were on
digoxin?

9 A. Some of them would have been
10 if they had heart failure, but it is very unusual in
11 tetralogy to have heart failure.

12 Q. But it is not unusual with
13 pulmonary stenosis to have heart failure?

14 A. No.

15 Q. And all I am putting to you
16 here -- I am certainly not trying to make this child
17 as in perfect health, but I certainly suggest to you
18 that she is the first child not on digoxin and it too
19 is another factor that indicates that in fact her
20 condition had not yet deteriorated to the point where
21 she was in obvious distress or failure or what have
you?

22 A. I think that interpretation
23 is a little too large because the problem with this
24 baby would not be heart failure. The problem would
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2 be hypoxia.

3 The problem is not failure of the
4 heart because of the big shunt or something like
5 that. The problem here is whether or not this baby
6 is going to get enough oxygen through this shunt,
7 and so we would not expect a frank and obvious heart
8 failure. What we would expect are hypoxic symptoms,
9 that is, increasing cyanosis.

10 Q. But again, sir, to follow that
11 up, have we not seen babies here that have exhibited
12 hypoxic symptoms and also been cyanotic and those
13 children too have been prescribed digoxin as that
14 drug that would assist them through that illness?

15 A. Yes, but there is a very
16 specific difference between babies who have reduced
17 blood flow to the lung and those who have increased
18 blood flow to the lung, and that would decide it. It
19 does not really -- you cannot put a blanket on that
20 issue.

21 Q. So it does not again strike
22 you as unusual that of the roughly 12 or 13 babies
23 that we have seen in that epidemic period up now
24 to the date of death of Lombardo December 23rd that
25 of all the patients here who are suffering from
these various cardiac ailments that young Lombardo



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2 here is the first one that is not even seen fit to
3 be put on digoxin?

4 A. It would be inappropriate to
5 put that baby on digoxin.

6 Q. I would suggest it would be
7 inappropriate, sir, but it is inappropriate because
8 of the fact that she is doing so well?

9 A. No, not at all. I do not
10 agree.

11 Q. Now, you indicated here, sir,
12 on page 2559 of your evidence to Mr. Lamek -- that
13 would be again in Volume 15 -- you make mention of
14 terminal events and what the medical staff felt was
15 the cause of death.

16 THE COMMISSIONER: Sorry, I missed
17 the page.

18 MR. SHANAHAN: Page 2559.

19 THE COMMISSIONER: Thank you.

20 MR. SHANAHAN: Q. Mr. Lamek put to
21 you at the bottom of page 2558 the lead question which
22 was:

23 "Q. Were any questions raised by
24 any of the cardiology staff or Cardiac
25 Fellows in the Hospital as to the
reason for this sudden decline and
death of this child?"



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2 And your answer on page 2559 commencing at line 4:

3 "A. I think there were questions
4 but the discussion really centred
5 around the precarious nature of the
6 shunt and the probable explanation was
7 thought to be that the shunt occluded
8 because no murmur was heard in the
9 period before the arrest and the know-
10 ledge of the anatomical and surgical
11 detail, the possibility that hepariniza-
12 tion wasn't effective led to the
13 conclusion which I believe was shared
14 by everybody, that the shunt had
15 probably clotted off."

16 A. Yes.

17 Q. Now, first of all, sir, the
18 fear was that there may in fact be a clot and that
19 that fear was responded to really by the one drug
20 that would in fact thin the blood and meet that very
21 problem, and that was heparin?

22 A. Yes.

23 Q. So, are you saying that your
24 concern was that there might be an occlusion even in
25 spite of the fact that this child was on one drug
and one drug only that we know of and that was heparin?



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A. Yes.

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Q. Jumping ahead to the baby that followed Lombardo, I think it is Baby Belanger, was there not also a concern in Baby Belanger's death, and I can assure the Commissioner I am not going to take a foray in there.

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THE COMMISSIONER: No, there could easily be a relevance. Do not misunderstand me.

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The only thing I was complaining about was the concentration on other babies rather than the baby whose parents you represent, and that is not happening here.

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MR. SHANAHAN: All right, sir.

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Q. As I recollect Belanger, and I may be able to put my finger on it if there is an issue here, but with Belanger too you had a concern that the shunt would be occluded and that in fact happily in Belanger you were able to get permission for a post mortem and on that post mortem you specifically found I think much to your surprise, as I recollected the notes to Mr. Lamek, that in fact much to your surprise Belanger was really a testimony to your good surgical techniques and Belanger pointed out that there was no occlusion of the shunt at all.

A. No, that is right.



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Q. That is right?

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A. Yes, that is correct.

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Q. Now, unfortunately in Lombardo you do not have a post mortem, but certainly at least when you look at it here and you come to the opinion that you think the shunt was occluded, you will grant me, sir, that there are occasions, and the ones we have covered, Belanger, as I say, sticks in my mind, when in fact your diagnosis having been restricted to purely clinical observations without the opportunity of a post mortem, that indeed there is room, large room for error there?

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A. I think those are two different patients, of course, and one of them had congestive failure, Belanger ---

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Q. Yes.

A. --- and the question that was

of concern was that maybe the shunt had become small because of atelectasis in the lung. But the fact is that there was failure, and I think it could be interpreted that the shunt was too big rather than too small. I think there were differences of opinion about that.

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But I think in Lombardo there was no difference of opinion about whether it was too big or



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too small. The question was how long could a shunt
that was that small go without the complication that
we thought we had seen.



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Q. Right, sir. I am in no way comparing their conditions at all. What I am simply saying to you, sir, is that when Mr. Lamek put to you about the cause of death before you had the post mortem results in Belanger, you said that it was the general feeling that, in fact, there had been occlusion of Belanger's shunt.

A. Yes.

Q. And subsequently you had a post mortem, and I won't put it that it registered even the surprise level, but it certainly, I thought you indicated then that it did come back, that the shunt was not occluded at all.

A. No, the shunt wasn't occluded.

Q. It was not occluded.

All I'm getting at, sir, is that in no way are the two of them the same and they presented different management problems for you but that where you did not on Lombardo have the benefit of a post mortem and you simply are looking at clinical symptoms, you will agree - and Belanger is the case I am using for support - that one can be wrong, as you look at the situation and get the subsequent post mortem results.

A. I think you can be wrong in a



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situation like Belanger, which is a very complex problem. With Lombardo, I wouldn't ever say that you cannot be wrong, but I think that the possibility, the sequence of events would be strongly suggestive that we were right.

Q. All right.

Now, sir, at that time, you have indicated there was certainly no -- one had to apply for permission from the parents to obtain a post mortem but that the post mortem that would be done would not do blood testing for digoxin, would not be routine at the time.

A. No.

Q. In fact, sir, as I understood it, too, it would not be routine to test for any of the drugs that a child was on?

A. That's correct.

Q. All right. But yet, at the same time, sir, as much as you would need at that time permission to have a consent for a post mortem, certainly you didn't need any consent and no one then would have needed any consent to simply have taken a vial of blood or vials of blood sufficient to do testing on the known drugs that a child was on at the time of their death?



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A. No.

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Q. No, all right.

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You indicated to Mr. Lamek, sir,
that this death was sudden and unexpected - I can
give you the page reference but I don't think you
will take issue with that.

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A. No.

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Q. And yet, sir, that being a
category clearly in the Coroner's Act that would
oblige you or others that deal with this child to
put it to the Coroner, why was it not reported to the
Coroner?

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A. I think that was a judgment
on the fact that the baby had severe heart disease,
it was known what the state of the pulmonary artery
size was and the size of the shunt, it was known of
the concerns about the viability of that shunt, and
it seemed like a perfectly natural explanation for
the death.

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Q. All right.

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You will agree that if it was
reported to the Coroner, the parents' refusal to
consent to a post mortem certainly would have been
circumvented?

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A. I don't know, that would



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depend on the Coroner.

Q. All right. Well, it could be circumvented if the Coroner shared your concerns after discussion with you, he could simply post haste order a post mortem.

A. He could.

Q. All right, sir.

Finally, sir, would it surprise you in this situation if I were to tell you that quite apart from the concerns that you felt about the shunt and the baby's condition that the parents of this child at the time felt that the child was progressing satisfactorily and that they based this on the information that they had received from the attending physicians in the Hospital?

MR. SCOTT: Well, which doctor is my friend referring to? Perhaps he can tell us the name of the doctor and we will make enquiries about it.

THE COMMISSIONER: Well, the question though was would it surprise you. I don't know that that necessarily means that the doctor has to be -- that might help, though, I suppose, if the baby --

MR. SCOTT: This is a cross-examination question and, if this were a trial, my friend would be obliged to give the name of the



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doctor who provided the family with that information
and undertake to call him to give evidence.

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Now, I am not asking for any of
that. I am simply asking if he is going to put a
question like that, which suggests he has knowledge,
would he be good enough to tell us who the doctor was
who informed the parents of this.

THE COMMISSIONER: Right.

What do you say, Mr. Shanahan?

MR. SHANAHAN: Well, Your Honour,
I can't give the name because I don't think my family
know the name, but I can perhaps approach this
question from another way that may be not quite so
offensive and, if I offend again, we'll take up the
issue then again.

THE COMMISSIONER: Yes, all right.

MR. SHANAHAN: Q. Doctor, you will
agree that parents, in there, normal, sensible, articulate
in there,
parents/ would be advised in general - now, you can't
speak to whether you dealt with the Lombardos but
in general - would be advised by a treating physician
and surgeon of the gravity of their child's illness?

A. I would hope so, yes.

Q. Right. And, certainly,
although one may not constantly wish to bring bad news



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to them, you really wouldn't want to have them operating under the illusion that their child had either a long, happy life ahead of it or it was really that death was very imminent. This would be conveyed each physician may be different how he would do it.

A. Yes.

Q. But this, I think, would be imparted to them, would it not?

A. Yes, I believe so.

Q. All right. And certainly nothing was to be gained here by giving any sense of false hopes to these people, even if a child made a day or a two-day or a three-day regrouping and looked better for two or three days, you really still would not transmit false hope to these parents?

A. No, not false hopes.

Q. That two or three-day turnabout would be put to them in the light of the overall chances of long-term recovery for the child?

A. I'm not sure what was said.

Q. And, again, we come back then to the point that Mr. Scott takes issue with. Would it surprise you if they had come to the general impression and the general conclusion that, in fact,



1
D7 2 the surgery had been successful and that their child
3 was progressing satisfactorily through all the
4 stages that the Hospital felt it should go through:
5 ICU to the ward and what have you?

6 A. I would be a little surprised
7 about that.

8 Q. All right. And it would
9 surprise you then, just to clarify that, that they
10 would feel, and have come to the conclusion, that
11 in fact their child was doing relatively well?

12 A. No, it wouldn't surprise me
13 that they might feel that their child is doing
14 relatively well because, indeed, on the ward he
15 appeared to be doing relatively well.

16 Q. She.

17 A. She, I'm sorry.

18 Q. All right.

19 A. She appeared to be doing
20 relatively well. But to what degree they were told
21 about the detail of the findings at operation and
22 the concerns that existed in the Intensive Care Unit
23 about the need to do another shunt, I cannot say
24 because I don't know what the people in those places
25 said, but I would be surprised if some of that wasn't
mentioned to them.



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Q. All right.

Well, just to take it one step further, and I mean this, sir, not just in their own laymen's observations, "Oh, baby looks pink today" or "Oh, baby has a smile". I'm saying in fact, without perhaps the detail we have gone into here about pulmonary stenosis and shunts and what have you, that in general the nature of the operation was described to them, the difficulties that were encountered were described to them and the long-term prognosis that was given to them was one of a fairly reasonable prospect of a long-term recovery.

MR. SCOTT: Well now, Mr. Commissioner, it isn't that I find this offensive, I don't, it is that I find it unfair. If my friend is asserting that a doctor told his clients this, I think we should know that, first of all, was it a doctor or was it a nurse. If he has the name of a doctor, I think, in fairness to the Hospital, I think he should tell us who the doctor was. If he doesn't have the name of the doctor, he can tell us the date, the time and the other factors that will enable us to run this question to ground.

THE COMMISSIONER: Well, he may not be able to give you much assistance on that because



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the parents are unlikely to have kept notes about
this.

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MR. SCOTT: Well, no.

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THE COMMISSIONER: But assuming
that the parents were told by a doctor, then we
don't know --

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MR. SCOTT: Well then, who did they
think it was? Did they think it was the surgeon or
have they any idea? Surely, my friend has some
obligation before he puts a suggestion like this.

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THE COMMISSIONER: Well, there is
the other part of it, too, Mr. Scott. I think he
has to put it, if he intends at some point to call
the parents to say that they did hear it from the
doctor, he has to put it to Dr. Rowe or to some
doctor so that there will be at least a warning or
an opportunity to deal with it.

17

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MR. SCOTT: Well, I presume he is
in effect undertaking to call this evidence.

19

20

THE COMMISSIONER: No, I don't think
he has to.

21

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MR. SCOTT: There is no formal
obligation but he wouldn't have put the question if
he wasn't intending to call that evidence.

23

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THE COMMISSIONER: Well, quite often,



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D10 2 you put the question and if you get the necessary
3 answer, then there is no need to call the evidence.
4 I am certainly not going to require him to do it now.

5 MR. SCOTT: No, no.

6 THE COMMISSIONER: But I am going
7 to allow the question anyway, Mr. Shanahan.

8 MR. SHANAHAN: I'm sorry, sir?

9 THE COMMISSIONER: I have now lost
10 track of the question but, anyway, I allow it.

11 MR. SCOTT: That gives you a good
12 opportunity:

13 MR. SHANAHAN: Q. Do you remember
14 the question, Doctor? You might be the only one
15 here that does:

16 MR. SCOTT: Oh, I remember it.

17 MR. SHANAHAN: Q. Well, I think
18 then, generally then, what it was was that the
19 parents had, I put to you, more than just a passing
20 layman's awareness of their child's situation, that
21 they had, without the sophistication of a medical
22 student, that they had been advised of the child's
23 condition and that they anticipated that the child
24 was doing well and would shortly be discharged from
25 the Hospital. Does that surprise you if they
laboured under that --



1
D11 2 A. I don't know because I don't
3 know what was told to them, but I would be surprised
4 if they weren't told more detail by surgeons and
5 the people in the Intensive Care.

6 Q. Right, sir.
7 Moving on to Dawson. With respect
8 to Amber Dawson, sir, I think the description of
9 her condition you gave to Mr. Lamek in Volume 12, and
10 it commences, sir, at page 2107 but I think you
11 really summarize it on page 2109. At the outset it
12 appears that this was an eleven-month old baby girl
13 that I think in her lifetime had a total of three
14 operations.

15 A. Yes.

16 Q. She had been in various
17 hospitals but had progressed through to the age of
18 eleven months. I think if we summarized her condi-
19 tion, and I am going to use your exact words in a
20 moment, she had holes in the walls of her heart and
21 she was also not thriving. She was in fact very
22 much underweight for an eleven-month old child.

23 A. Yes, she was.

24 Q. Right. And on page 2109,
25 in answer to Mr. Lamek's question about her condition and
about the diagram, you say at line 4, I think you



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D12 2 are more or less summarizing:

3 " I can tell you that in the
4 initial stages, the defects were
5 principally those of communication
6 between both the pumping chambers
7 and the receiving chambers, the
8 ventricles and the atria.

9 So, there was a defect or a
10 hole at the atrial septal level, a
11 hole allowing blood to pass from the
12 left atrium to the right."

13 However, you do say at line 15 of
14 the same page as you summarize:

15 "All the other structures in the
16 heart appeared to be normal as far
17 as I can recall."

18 All right?

19 A. Yes.

20 Q. Now then, sir, I think as well
21 at page 2114 of that same volume, you indicate that
22 the child is not getting on well, 2114, about line 11,
23 a question from Mr. Lamek commences and it ends with
24 another question:

25 "She just wasn't getting along very
well?"



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"A. That is right."

"Q. She was not growing, gaining weight and so on, and it was a complication as you have said of the paralysis of the right hemi-diaphragm, a phrenic nerve problem."

And then he goes on:

"At the time of her admission I understand she had been and was being treated with digoxin and aldactazide.

Doctor, are those drugs which are classically prescribed for congestive heart failure?"

"A. For congestive heart failure, yes."

So, she wasn't doing well, sir. She was in some degree of heart failure, but I think you can bear in mind as well, you will agree, that young Dawson had not been brought to the Hospital because of any specific event at home, we will say, contrasting that with a child who may have had seizures or really got sick or ill at home, she was simply an eleven-month old child who was coming to what she considered was the best hospital in the province for dealing with



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her problem.

A. Well, I think she had been in and out of hospital for the previous two months up north.

Q. I agree with you, sir, but what I am saying is there had been no radical event here which had caused her in any way to be rushed by ambulance or helicopter or something of that nature. She was simply brought in at will by her mother with a view to finally rectifying this heart problem.

A. No. I don't know that I read it that way, but I think that it was the continuing problem she was having in the other hospitals that I gathered was the reason she was sent down.

Q. All right.

I think you say here on page 2124, Mr. Lamek asking you a question at the top of that page:

"Doctor, you reviewed the course of the child and it was not all plain sailing, of course. Was there anything in the course that you have looked at that is disclosed in the record over the period from the 23rd to the 27th of July that would lead



Rowe
cr.ex. (Shanahan)

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you to believe that Amber Dawson
was at risk of imminent death?"

"A. No, but But I would qualify
that.

This sort of baby with
evidence of respiratory failure
developing is a high risk for
deterioration, but I would think it
fair to say that. hopefully that
could be managed."

So, you do set out the problem,
fair enough, the holes in the heart, and she is under-
weight, there is a problem there, but you also, it
seems to me, indicate that you feel, or you felt at
that time, that certainly you could look after her
condition there in the Hospital and manage her. She
wasn't at imminent risk.

A. Well, I think my testimony
tells you what I thought.

Q. Her pulmonary artery was
initially banded, is that right, sir?

A. Yes.

Q. Later, there were patches
put over the holes in her heart.

A. Yes. She didn't do very well.



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Normally, if you band the pulmonary artery at the age she was, a month when that was done, you would not normally do a full repair until about three or four years of age.

Q. Yes.

A. But she wasn't doing well and the only alternative was to do the repair at a younger age.

Q. All right.

And I believe it was during the operation with respect to the patches over the holes that the phrenic nerve got paralyzed?

A. Yes.

Q. All right. Is that, sir, just to digress for a minute here, is that, sir, something that happens? Is that commonplace? Is that normal?

A. Well, I don't know what the proportion is, but it is not uncommon; we see it not infrequently.

Q. All right. And would that, in itself -- what would that, from a clinical point of view, what would that do to a child?

A. Well, to an older child, it is not much of a problem.



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Q. Yes.

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A. But for a baby, it is a big problem because it interferes with their breathing --

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Q. All right.

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A. -- and the ventilation of the right lung.

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Q. All right.

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And did you not understand, sir - and I was a little unclear on this, but I thought that the phrenic nerve problem, sir, predated her admission to Sick Children's Hospital.

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A. Oh, yes.

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Q. It did. So, she dies, sir, on July 28th, five days after admission to the Hospital, and certainly the condition that you have described and the additional problem, if you like, of the phrenic nerve paralysis, these have all pre-existed during the entire eleven months of her life?

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A. Yes.

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Q. All right.

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Did you feel --

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A. Not the eleven months. The diaphragm was only two months paralyzed.

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Q. All right. That particular

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problem, that the additional problem had then only
existed for the last two months.

A. Yes.

Q. She was treated with digoxin
and aldactazide, is that right?

A. Yes.

Q. And, as I say, she dies
July 28th.

Did you think that - and I think
perhaps you did answer the question in the transcript
to Mr. Lamek - at that time, that a child who had,
as he put it, 'tottered through or staggered
through eleven months of life and three operations,
that for them to fall off the end of the table within
five days, that this was certainly sudden and un-
expected?

A. I said it was a sudden
deterioration but that there was an adequate explana-
tion for that. The ventilation was the problem.

Q. You certainly didn't call
the Coroner, did you?

A. No, I didn't.

Q. So, somebody else must have
felt that there wasn't an adequate explanation; is
that right?



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A. Well, I said that was a
borderline situation, as I recall it. I don't know
what my words were but I said I might not have
called the Coroner I think, but that was done.

Q. All right, Sir, I would
like to -- in her voluminous chart here, Exhibit
69, I believe are the charts of Amber Dawson. There
is an early description, sir, actually in late '79,
and I am going to bring it up to the final one that
we see here with the post mortem of Dr. Cutz. But on
page 505 of her medical charts there is a report
here, and you can perhaps tell me, it may be the
report after a cardiac catheterization, but it ends
up in a doctor there describing what in fact he
has observed about her heart and its various chambers.

Page 505, sir, if you have located
it.

A. Yes, I have it.

Q. All right. And I am going
to read that to you, sir. It says:

"The left ventricle is normal in
size and contractility. The aortic
root size is normal. In the four-
chamber view, one gets the impression
of fallout in the membranous portion



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of the ventricular spetum. Right heart structures are large but are probably not overly large for this age. Pulmonary valve is slightly bright and may show some evidence of systolic doming, indicating a valvar stenosis. This does not appear to be severe. Aortic valve appears normal. The suprasternal study of the aortic arch was also normal.

Diagnosis: Membranous ventricular septal defect."

Now, at one and the same time I know a septal defect, being a hole in our central organ, certainly is a serious abnormality and, yet, as I read that, sir, for the first time of a doctor looking at her on the 25th of the eighth of '79, I was struck, sir, by how much was normal about her heart.



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A. That is a report of an echocardiogram, and is the appearances that were observed by the cardiologist who is reading the videotape of the patient's study. I wouldn't say that is the definitive diagnosis of the patient's heart condition.

Q. You say it is a report of someone who did a cardiocatheterization?

A. No, it is a report of an echocardiogram, an ultrasound examination.

Q. All right.

A. Which is not the definitive study.

Q. It is not the definitive study, but I think very early in the game, as you described your techniques, you did say that an echocardiogram would reveal the inner chambers and valves of the heart, and certainly would provide you with an assessment of the condition of one's heart.

A. Well, I tell you that all the other evidence is against the notion that the chambers were of normal size.

Q. Well sir, we will get to that in a minute when we get to the final report here.

The terminal events of her death and the cause of death, you reviewed with Mr. Lamek in



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Volume 12, page 2129.

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A. Yes.

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Q. In the bottom of that page, sir,

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Mr. Lamek asked you:

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"Dr. Rowe, what in your judgment was
the reason for, or the explanation of,
the sudden and rapid decline in Amber
Dawson's case? I'm sorry, why did
Amber Dawson die when and in the way
that she did?

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A. I don't think we can be
absolutely sure.

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Q. And that, I take it, is why this
is one of the cases that was reported
to the coroner?

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A. I believe that is so.

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Q. Could you turn to page 66. Did
you participate in the decision to
report this case to the coroner?

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A. No."

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Again, on the following page, 2131, you
were asked, at the top, sir:

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"Why was it considered a coroner's
death?"

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Mr. Lamek, I believe, has reviewed with you, as Mr.

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Hunt did, that there are grounds that one would report misconduct, malpractice, pregnancy, unfair means, things of that nature. He finally said to you:

"Q. Why was it considered a coroner's death?

A. I am not absolutely sure. I think we would have to ask the cardiologist involved. I think that Dr. Izukawa and Dr. Olley were the two people involved with that family. I would personally think that there are good medical reasons why the baby might have died -- respiratory difficulty, respiratory failure in a chronically ill baby. I think it is a border-line situation for reporting to the coroner, and I think that perhaps it was a wise decision to do so."

And you repeated that again here today, and I accept that.

Down at the bottom then, he continues:

"Q. At page 63 of the record, which is part of the Coroner's Act Form of Post Mortem Report, and "cause of



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"death", the information is supplied by the pathologist, who is Dr. Cutz of the Hospital for Sick Children, is he not?

A. Yes.

Q. "The immediate anatomical cause of death not determined." "

A. Yes.

Q. And he gives attributing factors which I think we have discussed here today.

A. Yes.

Q. And he continues on the top of page 2132, around line 7, when he makes mention of a perforation in the stomach lining.

A. Yes.

Q. All right. Now, I think, as you indicated to Mr. Lamek, it was felt, it was thought by Dr. Cutz, I believe, that the perforation in the stomach lining may have been caused by the vomiting?

A. Yes, that was the interpretation.

Q. It seemed Amber Dawson was plagued by consistent and continuous vomiting?

A. Yes.

Q. And it would seem to me as well



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3 that Dawson is the only child, up to that point in
4 time, and the only child since, that in any of the
5 autopsy reports that we have that the vomiting was
6 so severe that in fact it lead to a perforation of
7 her stomach lining. I don't recall seeing any other
8 child who had that?

9 A. No. I think that is a matter
10 of opinion, it is not absolutely clear that the
11 vomiting caused perforation, that is the inter-
12 pretation of the pathologist.

13 Q. Fine, I will base it on that,
14 it is his interpretation and we certainly have not
15 seen such persistent vomiting in any other child as
16 to cause a perforation of their stomach lining.

17 A. No.

18 Q. And that in that situation it
19 was speculated, although Dr. Cutz doesn't have an
20 actual cause of death, I think you indicated it was
21 speculated, that this may have been the triggering
22 event that led to the ultimate cardiac arrest?

23 A. That has been suggested.

24 Q. And one other that I think
25 Mr. Lamek has carefully gone through with you, about
all the children, I think he put to you, with respect
to these two children, that I act for, Dawson and



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Lombardo, the fact that the many, many symptoms they displayed and the terminal events were consistent with dig. poisoning but is not this as well, sir, this persistent and violent vomiting to the extent that it caused a stomach rupture, would that not also be indicative, sir, perhaps amongst other things, of the massive overdose of digoxin?

A. I would think the length of the vomiting is against that possibility.

Q. Now finally, sir, then Exhibit No. 124 is the final autopsy report prepared by Dr. Cutz with respect to Amber Dawson. Do you have that in front of you?

A. No, I don't have that.

Q. It starts at page 59.

A. Oh, I'm sorry, yes.

Q. And page 60 of that, sir, describes, and I would like to read it here, what defects, and what he saw on his pathological examination and he says:

"This 11 month old infant had several hospitalizations and operations in the Hospital for Sick Children for correction of two ventricular septal defects and an atrial septal defect..."



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A. Excuse me, is that page 60?

Q. Yes, it is, sir. Am I wrong?

THE COMMISSIONER: You are right.

Q. This, sir, would be, as I have
it marked Exhibit 124, it is just as likely that I
have the wrong Exhibit number.

A. I have, page 60 is the second
page of the report of the post mortem.

Q. That is right, sir.

THE COMMISSIONER: Do you have one
there?

THE WITNESS: I have the second page
but 60 doesn't say anything about the patient's
description, it gives "face, neck, respiratory
system... et cetera."

THE COMMISSIONER: You will have to
read from that, Doctor.

MR. SHANAHAN: You have the right one,
Mr. Commissioner, that I was referring to.

THE COMMISSIONER: I have the right
one.

MR. SHANAHAN: All right. If you can
share it, that seems to be the theme here.

THE COMMISSIONER: We can both look
at it. Are we together there, Dr. Rowe, now?



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THE WITNESS: Yes, I have it now,
thank you.

Q. I have read the first three
lines and I am not going to reread them here.

First she underwent PA banding, and
there is a date given for that in 1979. Then "in May
this year, two VSD were closed and debanding
performed."

I take it the band was taken off
and they put in patches on the heart at that time?

A. Yes.

Q. "Post-operatively, she
developed RUL..."

A. That is right upper lobe of
the lung.

Q. "Atelectasis, or wet lung, and
right hemidiaphragm paralysis. Her
other problem was failure to thrive.
On last admission, she developed
vomiting following feeding and
arrested, resuscitation attempts had
been unsuccessful.

Autopsy showed that the
surgical repair of congenital heart
defects has been successful.



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3 "Ventricular and septal heart defects
4 have been closed and appeared intact.
5 There was a trivial deformity of the
6 pulmonary valve. Microscopic
7 examination revealed areas of old
8 myocardial fibrosis, consistent
9 with..."

10 And you will have to pronounce that word.

11 A. "Ischaemic changes".

12 Q. "... ischaemic changes.

13 Gastromalacia with perforation of
14 the cardia was a recent event, most
15 likely precipitated by vomiting."

16 I think that is what we just referred to, the
17 perforation on the stomach lining?

18 A. Yes.

19 Q. "There was evidence of
20 pulmonary collapse, but no
21 pneumonitis was found. The presence
22 of focal periventricular leukomalacia
23 is consistent with old ischaemic
24 insult."

25 A. Yes.

Q. It seems to me, Doctor, that
really, Amber Dawson, as they report on her anatomy,



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2 is really a testimony to the fact that the surgical
3 techniques used on her for the conditions that she
4 presented, those surgical techniques, were, in fact,
5 successful?

6 A. Yes.

7 Q. And, in fact, as he concludes,
8 and comes to page 67, the last page of his report,
9 page 67 of the Exhibit, in which he gives his final
10 impression, he speaks really of your surgical
11 techniques and what has been accomplished surgically
12 in glowing terms. Under the "final impression", he
13 says:

14 "(1) Post-operative repair of
15 separate membranes and in-let
16 ventricular septal defects with
17 excellent surgical result.

18 (2) Trivial deformity of
19 pulmonary valve with nodular
20 thickening in the free valve margin,
21 probably secondary to previous
22 pulmonary artery banding.

23 (3) Previously repaired main
24 pulmonary artery at sight of banding,
25 with an excellent surgical result.

(4) Suture closure of a



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2 patent foramen ovale."

3 Doctor, you analysed Amber Dawson's
4 condition, you used all the techniques to find out
5 what, in fact, was her problem. It turns out that,
6 in fact, you had the problem assessed properly. You
7 then used surgical techniques to address yourself to
8 that problem. As the post mortem demonstrates, those
9 surgical techniques were the right ones and they were
10 done successfully. Yet, after living 11 months,
11 Amber Dawson has severe enough vomiting that she
12 ruptures her stomach lining, which may be the
13 triggering cause of her final events, as she died
within five days.

14 A. That is correct.

15 Q. Do you not think, sir, that
16 that was a very, very sudden turn-around in a child
17 who had tottered around, at least for the first 11
months of its life?

18 A. No, I don't, because the baby
19 really had never been well. The weight of this baby
20 was incredibly low for that age. As I think we have
21 gone over before, babies who have failed to thrive
22 when they are in this sort of situation are really at
23 high risk.

24 Q. And again, sir, if I can bring
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2 you back to the aspect of the parental input here. If
3 I were to suggest to you that, in fact, that mother
4 attended with that child and had that child in and
5 around the ward, in her arms, and free from cardiac
6 monitors and IV, and the child, certainly to the
7 layman, however limited their judgment may be, but to
8 the layman, did not present as a child who within
9 five days would be dead.

10 A. No.

11 Q. Those are my questions with
12 respect to the two children finished.

13 I just have a few questions on a
14 couple of issues that have come forward.

15 Number one, sir, is the cluster theory.

16 I think part of what you indicated
17 in your evidence earlier to Mr. Lamek was that you
18 felt that you had an unusually high, I will put it in
19 my language, number of inordinately serious
20 anatomical defects around this period of time?

21 A. Yes.

22 Q. So, that struck me, as an
23 observer, that surely your reputation as a hospital
24 had attracted at all times, your reputation for
25 surgical expertise and what have you, was world wide,
and surely at all times, had it not attracted the very



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3 worst cases, the most difficult and problematic
4 cases?

5 MR. SCOTT: Does that include Dawson,
6 does that statement include Dawson and the other baby
7 that you are representing?

8 MR. SHANAHAN: It does, sir.

9 MR. SCOTT: It does, very well.

10 Q. You, at all times, had
11 attracted the most difficult and problematic cases?

12 A. Yes, such as were sent to us.

13 Q. Sir, you will agree that after
14 the events in March, you certainly then did not in
15 any way attempt then to remedy this epidemic, or this
16 cluster of deaths by in any way filtering out the
17 more serious from the less serious, you, once again,
18 took those cases that came to you, however serious
19 they might be?

20 A. Yes.

21 Q. And certainly, sir, as I read
22 it, and as I read the various reports, the conditions
23 that you saw, the many conditions as they overlapped
24 at times, tetralogy of Fallot, pulmonary stenosis,
25 with many other things, these were all things that,
as you gave your evidence here, not that you seemed
comfortable with, but that you seemed to be fully



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conversant with those individually and when they
interacted with each other.

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A. I was comfortable with what?

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Q. You were fully conversant, none
of things were ailments or conditions which you had
never seen before.

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A. Oh, no.

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Q. And certainly, since the
epidemic period, you have received just as serious a
case, and treated them in just the same manner,
varying, of course, individual to individual?

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A. Yes.

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Q. And you will agree that none
of the numbers with respect to the high ratio of
death has ever cropped up again?

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A. No, that is correct.

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Q. Sir, with respect to the
nursing concern. You indicated to Mr. Lamek that one
of the first things that set in motion any of the
internal examinations or considerations, if you like,
with respect to the number of deaths that were
localizing on a ward within a certain age group of
children, within a certain nursing team, and within
a certain time of the day, was that the nurses
themselves, through a head nurse, came to you and



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2 expressed their concern?

3 A. I think it was a Nurse
4 Specialist?

5 Q. A Nurse Specialist, all right.
6 As I looked at this hospital, as I, an outsider,
7 assessed it, really, there were two bodies of
8 professionals working side by side every day with
9 respect to the care of these children. If I lump
10 them generally, there were doctors on one side, with
11 all the various breakdowns of Fellows, interns and
12 what have you, there were doctors on one side and on
13 the other side was the nursing body, nurses, RNAs and
14 what have you.

14 A. Yes.

15 Q. They were the two professionals,
16 at 24 hours a day, that were really co-ordinating
17 efforts to assist these children?

17 A. Yes.

18 Q. It struck me, sir, as an
19 outsider, surprising that really as between the two,
20 the less experienced, if you like, of the two groups,
21 without the assistance of graphs or charts, or
22 without resorting to any hospital record, that they,
23 my gut reaction felt, that the numbers were too high
24 and that the frequency was too high of these deaths.
25



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2 That struck me, as an outsider now, as very surprising.
3 I put to you that when you were approached, you
4 personally, or your group of cardiologists, were
5 approached, that it was really quite a shocking
6 experience for you fellows to be told by nurses that,
7 in fact, they suspected something was amiss.

8 A. I don't think that was the
9 impression I got.

10 MR. SCOTT: I am sorry to interrupt,
11 but that is a very long question. If you are attempt-
12 ting to summarize some other evidence, I don't know
13 what it is.

14 THE COMMISSIONER: I have no
15 difficulty with the question. Well, was he affected
16 by the fact that it was the nurses who approached him
17 rather than the doctors.

18 MR. SCOTT: If that is the question.

19 THE COMMISSIONER: Is it not
20 surprising that the nurses first expressed concern
21 and not the doctors?

22 MR. SCOTT: I think the problem is
23 the question is so long that the answer, yes, or no,
24 you are jostling a whole lot of adjectival ---

25 THE COMMISSIONER: All right. Do you
want, Mr. Shanahan, to summarize the question again



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2 perhaps in fewer words?

3 MR. SHANAHAN: All right.

4 Q. Does it surprise you, sir, that
5 without the assistance of any graphs, resorting to
6 any head counts, that from a gut reaction, the
7 nursing staff was coming to the doctoring staff, if
8 you like, and expressing a concern about the number
9 and frequency of the deaths?

10 A. When that was done in August,
11 I was a little surprised that they hadn't got the
12 feedback from everybody about how severe the patients
13 they were concerned about were affected, how severely
14 they were affected and that was the purpose of the
15 first meeting, you will recall.

16 Q. Really, sir, even bearing in
17 mind that, these nurses were nurses that were
18 experienced nurses. I think you indicated in various
19 evidence that certainly they acquire, after their
20 training for a cardiac ward and for the wards, they
21 certainly would acquire quite an expertise in dealing
22 with these children and assessing their condition.

23 A. Yes.

24 Q. Do you agree?

25 A. Yes.

Q. If you had had these conditions



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in the hospital before the epidemic period, surely they too had seen and dealt with tiny children, desperately ill with those kind of conditions?

A. Probably not as many.

Q. What do you mean probably not as many, what do you mean by that?

A. Probably not as many desperately ill, sick and small babies.

Q. All right.

A. Because we didn't have as many babies in the infant beds on the ward before.

Q. Sir, you being involved with cardiac for how long, dealing with and treating them?

A. About 33 or 34 years.

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Q. Had you, sir, before had on a ward that you were dealing with nurses through the auspices of one spokesman come to you and say to you that in spite of all your surgical expertise and what have you that in fact they felt too many children were dying?

A. That was not the message I got from them.

Q. First of all, what was the message you got, then I will give you the question again?

A. The message I got was that they were concerned that something they were doing about these babies who had died during July and August, something they were doing might be contributing to the problem, /that they were not doing enough, let us put it that way. That was the message I got.

Q. All right. I think the latter part now -- I will not take issue with that. You did seem to say that before, but let us be fair. They were tying that in not to some vague feeling, they were tying it into the fact and these children were dying in large numbers?

A. Yes.

Q. They felt they were not doing



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enough?

A. Yes.

Q. There was maybe more they could do because a lot of children were dying?

A. Yes, that was about seven babies by the time they came to me.

Q. Well now, they reacted to seven babies. That caused their hackles to go up.

What I am saying to you then is had you ever before had even that kind of concern, we are not doing enough, there is a lot of children dying in your 33 years before, ever had that happen?

A. I have had that happen occasionally where nurses have been very concerned about a death and they were uncertain about whether they could have done more or not because they did not have at that time the complete diagnostic situation revealed.

Q. I am not asking though specifically. I appreciate the answer. I am not asking specifically about a nurse about a particularly tragic death. I am talking about nurses collectively getting one person, a supervisor or whatever you describe her as, to come to you about seven deaths that they were concerned about?



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MR. SCOTT: Well, Mr. Commissioner,
that is not the evidence we have had.

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MR. SHANAHAN: That is the evidence
he just gave.

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MR. SCOTT: The evidence is that
a nursing specialist came to Dr. Rowe. There is no
evidence as yet that the nurses collectively banded
together or anything like that.

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THE WITNESS: No, that is true.

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THE COMMISSIONER: All right. Well ---

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MR. SHANAHAN: Well, one -- sorry,
sir.

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THE COMMISSIONER: No, there may be
a misstatement. I am sure if there is one it is
not deliberate. But in any event, the problem is
whether a similar situation such as this had occurred
in the past.

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THE WITNESS: No, I have not had
that.

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MR. SHANAHAN: Q. All right, that
is fine. I will not be too long.

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THE COMMISSIONER: Well, it is
whatever you like now, Mr. Shanahan. Do you want
to finish?

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MR. SHANAHAN: Can I forge ahead

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and just finish up?

THE COMMISSIONER: Yes, by all means.

MR. SHANAHAN: Q. Finally, again, in terms of looking at these babies, as I went through it I was surprised that in spite of the severe anatomical problems they had that many did not or were not being treated by large numbers of drugs. For instance, Lombardo had heparin; Dawson had digoxin and aldactazide. And as I went through others, sir, and looked at them, I was surprised that although their condition was very severe, and I am not saying you did not respond, you did, you had cardiac monitors and operations, but that the drugs were few and they were clearly named and set out?

A. Yes.

Q. And you would agree, sir, that the effects of these drugs obviously known to the doctors prescribing, but that these nurses too would achieve a degree of sophistication that they would know, well, this is a diuretic and it would cause, it will assist the patient in having a good fluid output?

A. Yes.

Q. And this is digoxin and it will assist in regularizing and strengthening the



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2 heart beat to prevent the patient falling into
3 cardiac, or sorry, congestive heart failure?

4 A. Yes.

5 Q. These things would be
6 generally known?

7 A. Yes.

8 Q. All right. And as well as
9 that I would submit to you that at least of the
10 doctors' staff and maybe as well to the nursing
11 staff that you would have, they would have a general
12 knowledge of what to look for as one would move into
13 the area where these drugs were not doing the purpose
14 they were set out for that were in fact poisoning or
15 harming the patients?

16 A. Yes, I think they would have
17 an idea of those things.

18 Q. An experienced nurse would
19 have learned or should have learned in school and
20 through her experience that if you had a massive
21 dose of heparin, for instance, and I certainly
22 do not know what the symptoms are, but I guess the
23 blood would get so thin and she would be aware of
24 at least visually being able to see what the warning
25 signs might be?

A. If it were massive she would



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3 cardiac, or sorry, congestive heart failure?

4 A. Yes.

5 Q. These things would be
6 generally known?

7 A. Yes.

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11 staff that you would have, they would have a general
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14 they were set out for that were in fact poisoning or
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16 an idea of those things.

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19 through her experience that if you had a massive
20 dose of heparin, for instance, and I certainly
21 do not know what the symptoms are, but I guess the
22 blood would get so thin and she would be aware of
23 at least visually being able to see what the warning
24 signs might be?

25 A. If it were massive she would



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see it because of bleeding, but in the ordinary course of events she would not be able to judge it. You would have to have a test to judge the effect.

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Q. All right, but in any event, whatever the drug would be, be it heparin or be it the diuretic drugs or what have you, and as you have indicated there were not that many in play, that in fact a nurse would know what they were for and would know generally when the patient started to move into the region where these drugs were being harmful and toxic, would know the clinical symptoms?

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A. Yes.

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Q. All right. Digoxin was readily available. There was no count on it and certainly access to it was wide open; you have given that evidence?

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A. Yes.

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Q. You agree, sir, that it would certainly not have taxed the Hospital's present facilities then to, quite apart from routinely sampling the blood specimens for the drugs that patients were on during their life, that it would not certainly from an economic point of view have taxed their facilities to have routinely done sampling on the known drugs a child was on at death?



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A. No.

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Q. You will agree, sir, that with respect to Dawson we certainly now, quite apart from having a post mortem, we could once and for all put to rest whether Dawson had had an overdose of digoxin?

A. I am sorry, could you repeat that question?

Q. If Dawson had had a routine digoxin test done --

A. After death?

Q. After death.

A. I do not know.

Q. And, sir, with respect, then, to the mimicking symptoms that this digoxin has displayed, I put to you that as you looked at these deaths and all the other factors that you had, and your evidence was that at no time unfortunately did you ever connect all these factors together, the factors of the age, the time these children were dying, the place in the Hospital they were dying, things of this nature?

A. Well, we knew they were young and we knew they were sick and we knew they had bad malformations.



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Q. Although the question, sir, of digoxin, as I see it in various reports comes up, will say "dig. toxicity?", the connecting factor and there is no fault attributed here from me, the connecting factor is never really made to the extent, well, let us just lock up the digoxin, let us start there?

A. Oh no.

Q. Nothing dramatic as firing people or disbanding nursing teams but just let us put a lock and key on the digoxin?

A. Yes.

Q. And you will agree, sir, that if anyone here looking at these conditions, any one person or persons were perverse enough or bad minded enough to engage in that course of conduct that Mr. Percival put to you of euthanasia, or mercy killing of these children, that in fact the one drug only that could so ideally mimick the terminal events of cardiac failure, the only one drug that would do it was digoxin?

A. Or potassium.

Q. But potassium was not being dished out in a syringe into babies' bodies, was it?

A. But it was available.



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3 Q. And, sir, the only chance
4 for someone who would know that (a) consent had to
5 be obtained for post mortem, and (b) even if the
6 consent for post mortem was got in this Hospital,
7 they do not test for digoxin, that the only chance
8 of being caught out was really twofold: number one,
9 that some suspicious person, I guess it is a fox to catch
10 a fox, some suspicious person would have their nose
11 in the air sniffing about and would say in this case
12 I want a digoxin test, and that was done and
13 eventually did achieve some results, but that was
14 one way a person would be caught out; is that right?

15 A. I am not sure that I understand.
16 You mean one way you would be able to find there was
17 high digoxin ---

18 Q. Well, bearing in mind the
19 general policy of the Hospital that even if there
20 was a post mortem there was no testing done for
21 digoxin?

22 A. No.

23 Q. And that if someone knew this
24 and was dispensing toxic doses of digoxin, they were
25 safe unless, number one, a doctor became suspicious
and ordered of his own account a test?

A. Yes.



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2 Q. Or as happened very late in
3 the day in March, where that person shared with the
4 doctors the feeling that there was an anatomical
5 defect but that subsequent post mortem bears out
6 that indeed there was no anatomical defect and
7 therefore the terminal events should not have been
8 as they were?

9 A. Yes.

10 MR. SHANAHAN: Let us take our
11 break and I can finish after.

12 THE COMMISSIONER: Well, whatever you
13 like, whichever you prefer.

14 MR. SHANAHAN: Q. All right. The
15 last point is some of these hypothesis that
16 Mr. Strathy put to you.

17 Mr. Strathy put to you, I thought he
18 said, well, Doctor, you know, when you get down there
19 and call a Code 25 and all the doctors come in there
20 and the nurses that it is really pell-mell and it is
21 so hectic that is it not conceivable that many things
22 can go astray there, and yet, Doctor, as I read all
23 these terminal events and the Code 25s that were
24 called, I was really struck with quite the contrary
25 impression. I was struck by the fact that all
proceeded, it appeared to me, in an orderly fashion



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2 that people had designated roles to play, that the
3 drugs were at their hands and that they proceeded
4 to various procedures in a set regular fashion; is
5 that not right?

6 A. Well, I think that is an
7 over-simplification of what goes on at an arrest call,
8 and if you were at an arrest call you would see the
9 point that was made. I think there is tension and
10 I think I have mentioned that before in testimony,
11 and it is well known by the pharmacologists that
12 this is a time where there can be errors in administra-
tion.

13 Q. All right, but quite apart
14 from the fact that you have said that subsequently
15 I do not think there was any digoxin found on the 4A
16 crash carts, I mean if there is no digoxin on those
17 crash carts as a solid fact, that really rules out
18 his hypothesis, but assuming for the sake of argument
19 that digoxin was on, I would still suggest to you,
20 sir, that although things are urgent and they are
21 hectic, that as I saw them in some of these exhibits
22 there were set -- they were intubated, adrenaline
23 was given, they went through a set scenario, they
24 tried to defibrillate, people were not just walking
25 up to the body and sticking things in at random?



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3 A. No, but the question has not
4 been decided because there is no way of doing it
5 whether all the drugs that were given during
6 resuscitation are entered on the record. I am not
7 suggesting that there is not order to this at all.
8 I think people do this in a very highly efficient way
9 usually. But because of the nature of the situation,
10 there is the possibility of (a) somebody not putting
11 down what they gave, or (b) something being given by
12 mistake.

13 Q. All right, sir. Mr. Strathy
14 put to you that to achieve a large reading on a child,
15 and I forget the child he dealt with, but to do that,
16 at another point in time in his cross-examination of
17 you he said, and I think he presented to you a small
18 vial of digoxin and he said, well, we have to break
19 open 20 of these and it seemed to me put it in a
20 syringe that was large enough for a horse?

21 A. He was referring to
22 Dr. Hastreiter's testimony, and I was agreeing with
23 what Dr. Hastreiter had said, but I do not agree
24 with the statement of Dr. Hastreiter. I think it
25 has been subsequently shown not to be true.

Q. All right, but Mr. Strathy's
scenario that somebody, if those terminal events



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3 after a Code 25 was called would be methodically
4 standing aside, that the killer here or whatever
5 would be standing aside filling up a syringe just
6 simply is just not feasible?

7 A. That is based on Dr. Hastreiter's
8 testimony. If it was a single ampule that was
9 involved it would be feasible.

10 Q. And finally, sir, Mr. Strathy's
11 proposition to you certainly did not -- I think you
12 have been guarded and we have been guarded until we
13 get better evidence. We have been made aware that
14 there is a phenomenon of digoxin in tissue after
15 death multiplying or at least the readings coming
16 out, that there is a multiplier effect?

17 A. Yes.

18 Q. The details of which we do not
19 yet know?

20 A. Yes.

21 Q. But certainly I thought that
22 Mr. Strathy's proposition was put to you without
23 any care being taken about factoring out any range
24 of this multiplier whatsoever. Mr. Strathy put to
25 you an enormously high reading, had you say this
would take 20 vials/^{here} and put to you that, well, 20
vials would be an enormous dose, we do not



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3 even have syringes for that.

4 MR. SCOTT: Now, Mr. Commissioner,
5 in Mr. Strathy's absence, that is not a question.
6 I mean, that is an argument that is to be made
7 against Mr. Strathy's thesis, whatever it was.

8 THE COMMISSIONER: But Mr. Strathy's
9 thesis was put to Dr. Rowe, so surely Mr. Shanahan
10 can put the same criticism of a thesis to the same
11 witness.

12 MR. SCOTT: Well, can he do it in
13 a one sentence question so that we can know what the
14 question means instead of these elaborate statements
15 that have a question mark at the end.

16 MR. SHANAHAN: Q. I put to you when
17 when Mr. Strathy put the proposition to you about
18 how many vials it would take to achieve a very high
19 dose, that he left out that whole area of digoxin and
20 tissues multiplying after death?

21 A. I cannot remember that.

22 Q. Well, I put to you that he
23 did, and I put to you that in fact the level that
24 would have to be given is not simply the level that
25 may be found in exhumed tissue many months later.
All that would be required would be a toxic level
which would later do its own multiplying in the tissue



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2 many months later?

3 A. Sorry, I have lost you again.

4 MR. SHANAHAN: Did I lose you,
5 Mr. Commissioner?

6 THE COMMISSIONER: No, I do not
7 think you lost me. I was beginning, though, to
8 agree with Mr. Scott, there was more argument than
9 question.

10 MR. SHANAHAN: Q. Well, one last
11 question here. With respect to Lombardo that is
12 no explanation at all anyway because you will agree
13 that Lombardo was not to have any digoxin whatsoever
in her system?

14 A. That is right.

15 Q. So whatever readings we
16 have many moons later and whatever we finally decide
17 upon as the multiplying factor, the simple fact
18 remains with respect to Lombardo that none was
prescribed in that Hospital?

19 A. Correct.

20 MR. SHANAHAN: Thank you, sir.

21 THE COMMISSIONER: Thank you,
22 Mr. Shanahan. We will take 20 minutes.

23 ---Short recess.
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--- on resuming.

THE COMMISSIONER: Yes, Mr.

Shinehoft.

MR. SHINEHOFT: Thank you, Mr.

Commissioner.

CROSS-EXAMINATION BY MR. SHINEHOFT:

Q. As they say, Doctor, last but not least.

Before I get into your cross-examination, Doctor, there is one matter that I would like to speak to the Commissioner about, and --

That is with regard to the Dubin report, Mr. Commissioner.

Now, I garner from comments that you made last Thursday that you felt it was inappropriate for myself or any counsel to ask this witness or any other witness questions in regard to that report. Am I correct or incorrect?

THE COMMISSIONER: No, I don't really mean that. I meant that I didn't want to go over the same ground that the Dubin Inquiry had gone over, at least I was not supposed to. I have special terms of reference. But if something in the Dubin report is relevant to this inquiry, there is no reason why you can't ask the witness with respect to it.



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G2 2 But I don't, for instance, consider that the general
3 management of the Hospital is any of my concern,
4 whether there are enough nurses or whether there are
5 enough doctors. The only way it could conceivably
6 be relevant would be if that had contributed to the
7 deaths of these children.

8 I was indicating to Miss McIntyre
9 I thought that the evidence did not seem to show that.

10 MR. SHINEHOFT: I can appreciate
11 that, Mr. Commissioner, but as you are, I am sure
12 aware sometime in the future, and God knows when
13 that is going to be, counsel are going to be making
14 certain submissions and I feel that it is appropriate
15 as we go along to ask certain questions of the
16 doctors as far as this report is concerned.

17 THE COMMISSIONER: Remember, it has
18 to be relevant to what the terms of reference that I
19 am faced with, that's all.

20 MR. SHINEHOFT: I appreciate that,
21 Mr. Commissioner, and my question may be only one
22 question.

23 THE COMMISSIONER: All right. Well,
24 better to have the one question than worry too much
25 about whether it is relevant.

MR. SHINEHOFT: Q. I understand,



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Doctor, that you have read the Dubin report; is that correct?

A. Yes.

Q. My question very simply is, do you agree with the information and the recommendations that are made in that report?

THE COMMISSIONER: That would be a long answer. It may be a short question but it is a very long answer.

MR. SHINEHOFT: My friend, Mr. Scott, wanted very short questions and I am trying to accommodate him, Mr. Commissioner.

THE COMMISSIONER: I think I will have to say he can take the advice of counsel, who seems to be absent from the room at the moment.

MR. SHINEHOFT: Well, that may be my only shot at this question.

THE COMMISSIONER: Well, I will leave it up to you, Dr. Rowe. If you want to answer it, you can answer it but if you don't want to answer it you don't have to.

THE WITNESS: Well, I can say that I am in agreement with the recommendations he has made in regard to cardiology.

MR. SHINEHOFT: Q. Okay.



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And what about the factual information upon which those recommendations are made? Is there any area specifically that you would disagree with the information as it is contained in that report, Doctor?

A. I think there are areas in there -- I have reviewed the documents and I have notes on the areas that I am in some disagreement with, but I mean, to say am I in total disagreement with the document would be wrong.

Q. No. This leads to my next question, Doctor. Perhaps - and, again, Mr. Commissioner, you may have some comments as to the relevancy of it. I think it is, and I think it is going to be made, the relevancy of it is going to be made more aware as we get into this investigation, into this commission, but could you tell me, Doctor, the areas in which you disagree with the Dubin report and for what reason you do disagree with the comments made in the report.

THE COMMISSIONER: Well, that could conceivably be relevant but probably isn't, because the Dubin report covered all sorts of matters with which we are not concerned.

MR. SHINEHOFT: I see. Well, there



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are about a half dozen areas that I would like to speak to the doctor about specifically.

THE COMMISSIONER: I don't seem to have the Dubin report. Have we got that?

Okay, I have one now.

What areas are you thinking of?

MR. SHINEHOFT: Well, I will give you the page reference. The page references that I would like to have some input from Dr. Rowe on are 37, 56 --

THE COMMISSIONER: Well, dealing with them one at a time, why would the Board of Trustees, why would that be relevant to our inquiry?

MR. SHINEHOFT: Well, the report refers to lag time, and the question as to whether the Board, in its committees, are being kept fully aware of major events occurring in the Hospital for which they have legal responsibilities.

THE COMMISSIONER: Look at the terms of reference. The terms of reference, I have to consider this report with a view only to avoiding repetition of evidence, to enquire into and report and make recommendations with respect to how and by what means the children who died in cardiac wards 4A and 4B came to their deaths and then to investigate



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the prosecution, or at least enquire into the investigation and prosecution of Susan Nelles.

MR. SHINEHOFT: Mr. Commissioner, I am not going to belabour the point but I feel, if this is correct that there were certain problems with information being disseminated to the correct bodies, to the correct people, that that might be a factor that this Commission would --

THE COMMISSIONER: Well, it is conceivable it might be very, very remotely relevant but, if it is going to be, if that is the test whether something very, very remotely relevant is to be received, I am going to take a negative approach. It is perfectly clear that we are going to be lucky to finish this thing within the foreseeable future. If we start enquiring into -- it took the Dubin Committee, I don't know, but it took them many, many months to produce this thing, and I certainly can't go through that.

MR. SHINEHOFT: And I don't expect to go through it.

THE COMMISSIONER: As far as the conduct of the Board of Trustees is concerned, if it is relevant at all, it is so remote that I would reject it.



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Now, what's the next subject?

MR. SHINEHOFT: The next thing is the comment on the medical staff representation at page 56.

THE COMMISSIONER: Representation where?

MR. SHINEHOFT: Well, it is a quarter of the way down. It says, "Comment on medical staff representation". The function of the elected officers, and it goes on from there, Mr. Commissioner.

THE COMMISSIONER: What does that have to do with our inquiry?

MR. SHINEHOFT: Well, again, it is a question of input into what should or should not have been done; for example, reporting cases to the Coroner, for example, a method of treatment for setting up some kind of an intermediate Intensive Care Unit.

THE COMMISSIONER: Well, some of those things, of course, you might well be able to touch on - they have been touched on already - but what has the Dubin report got to say on this that is really helpful to our inquiry; that's all?

MR. SHINEHOFT: Well, I only wish to present to Dr. Rowe the comment that is made and to



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ask him simply does he agree with that or does he disagree with that. I don't intend to go into this whole thing at length, and I will defray from getting into it at all if you feel --

THE COMMISSIONER: But what is it going to -- maybe it helps us and maybe it doesn't, and I am not being insulting to Dr. Rowe, but, really, what does it matter whether he agrees or disagrees with the Dubin report?

MR. SHINEHOFT: That may be --

THE COMMISSIONER: I suspect there will be a lot of people disagreeing with whatever report I bring out.

MR. SHINEHOFT: Well, I will leave the issue, Mr. Commissioner.

Q. Let me ask you this, Doctor. Would it be fair to say that one of the difficulties that you have had here is the fact that you are coming to a quasi legal proceeding and you are trained and skilled as a doctor and that you have had to explain concepts, ideas and certain words, and we, as lawyers, might very well interpret those words differently than you as a doctor? Do you agree with me on that?

A. Yes, I get that impression.



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Q. Words like 'suddenly' and 'unexpectedly' and 'arrests'; we have heard 'unusual', and we have had tremendous difficulties with defining these words and explaining the meaning of those words; would you not agree?

A. Yes.

Q. And I think you agree that partially may be due because of your training and experience as a doctor --

A. Yes.

Q. -- whereas, we are in fact trained and experienced as lawyers?

A. Yes.

Q. Would you agree with me, Doctor, that if a person were trained as both a doctor and a lawyer, trying to explain some of these concepts to us, this might be easier for that type of person to do so?

THE COMMISSIONER: It might be spread too thin.

MR. SCOTT: Overeducated.

THE COMMISSIONER: Overeducated.

MR. SHINEHOFT: Q. Would you agree with me?

A. Yes, I would.



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Q. I am sure you are aware,
Doctor, that there are these people who are both
doctors and lawyers.

A. Yes.

Q. And these people write books.

A. Yes.

Q. And I am going to refer to
a text that has been written by a person who is both
a doctor and a lawyer and I am going to ask you some
questions about some of the comments that have been
made by this author, and the text I am going to refer
to is called "Medical Practice For Trial Lawyers". It
is written by J. Stanley McQuay, LL.B., M.D., Ph.D.,
and I have his curriculum vitae, Mr. Commissioner.

THE COMMISSIONER: I don't want it,
thank you. I don't want it, no. It is what the
witness says about; not what the book says.

MR. SHINEHOFT: Okay.

This doctor happens, as well, to
have a Ph.D. in Philosophy.

MR. SCOTT: Where is he at school
now?

MR. SHINEHOFT: He as well, Mr.
Commissioner, founded a law school.

MR. SCOTT: Sounds absolutely



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incorrigible. What was his name again?

MR. SHINEHOFT: For my friend, I happen to have a curriculum vitae.

MR. SCOTT: He was born in Ireland.

MR. SHINEHOFT: He addresses this problem as well. He says in his Introductory, at page vii --

THE COMMISSIONER: I hope this is a question.

MR. SHINEHOFT: I just want to know if he agrees with it, that's all.

THE COMMISSIONER: Oh, all right.

MR. SHINEHOFT: I am going to read part of it and it might be of assistance to what has happened here. I will make the book available to anyone who wants to read it. Very boring reading, Mr. Commissioner.

He says:

"Despite the ready availability of all these sources and expert opinions, medical cases are still difficult for the lawyer to understand. Even nowadays when medical information is more available and indeed more commonly spread around by mass media,



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the lawyer is a stranger and a
foreigner in the world of medicine.
The purposes of the doctor and the
lawyer are totally different and the
information given in a medical
report may not answer the lawyer's
questions."

Q. Do you agree with that, Doctor?

A. Yes.

Q. He goes on to say:

"Unfortunately, the lawyer may not
be able to determine precisely what
questions he ought to ask."

This is maybe why your cross-
examination has taken so long, Doctor, we don't know
what questions to ask you.

THE COMMISSIONER: I wonder if you
could get down to the questions you do want to ask,
if you happen to know them. I really don't want any
more of this. I'm sorry. It is delightful and I am
almost at the point of promising you I will read the
book in order to avoid your reading it to me.

MR. SHINEHOFT: Q. Well, there are
certain areas that I think are somewhat relevant to
the evidence that you have given, Doctor, and if I



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could refer to one of them. This author talks
about drug errors and problems. He says:

"The most common drug error is that
the wrong medication or the wrong
dosage is given. This may happen
through mistaken identity of the
patient or some mistake in tran-
scribing the orders or simply through
carelessness."

Would you agree with that, Doctor?

A. Yes.

Q. He goes on to say:

"But whatever the reason and when-
ever there is a drug error, a full
investigation must take place even
though the error was harmless; for
example, the patient was given a
sugar lump instead of an aspirin.
The theory for this strictness is
that the matter might well have been
more serious and the root cause of
the error should be pinpointed and
eliminated right away.

Would you agree with me on that,

Doctor?



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A. Yes, yes.

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Q. And was this the course of

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conduct that was taken as far as the Velasquez case?

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A. Yes.

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Q. Did you do that?

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A. Yes.

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Q. And did you follow what this

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author suggests is an appropriate course of action
when there is a drug error?

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A. Yes.

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Q. And there was also reference

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made to two other drug errors, two other cases of

13

drug errors, where there were reports that were taken,
incidence reports, I think you call them.

14

A. Yes.

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Q. And was that procedure followed

16

as well, Doctor?

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A. Yes, it was.

18

Q. So, there is a definitive

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organized procedure to follow whenever there is a
question of an overadministration of a drug?

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A. There is an incident report.

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Q. An incident report?

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A. Yes.

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Q. And you feel it fulfills the

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criteria that this author suggests should be done
when a drug error happens?

A. Yes.

Q. He goes on to say - he talks
about the side effects of drugs and he says:

"Digoxin has probably saved many
more lives than any other drug but
has cost a few by starting arrhythmias
in susceptible patients. Digoxin
works more powerfully when a patient's
potassium is low."

Do you agree with that?

A. Yes.

Q. Well, didn't you say, Doctor,
something to the opposite yesterday when we were
talking about a high potassium level and a high
digoxin level?

A. Yes.

Q. So, are you agreeing with
the author?

A. I am agreeing with the author
and I am agreeing with what I said yesterday.

Q. Okay. Could you explain that
to me.

A. Well, if you have a particular



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level or distribution of digoxin in the body and the potassium level in the blood is reduced for any reason, usually because of diuretics but sometimes for other reasons, then the effect of the digoxin on the myocardium is enhanced and the patient may show toxic effects --

Q. Yes.

A. -- from the drug. The relationship of high potassium to massively high doses of digoxin is a matter I am not terribly conversant with but the level does rise when you have very high doses. This is a different situation from what happens if you have low potassium that is induced by some other cause.

Q. But correct me if I'm wrong, Doctor, but when the discussion was, when you were examined about an antidote to digoxin intoxication, didn't you suggest that one of the things that you would give would be potassium?

A. If the potassium level is low. If the potassium level in the blood is low, you can give potassium to help.

Q. I see. So, that is the qualification that you would make on giving potassium?

A. Oh, yes. You shouldn't give



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potassium to anybody whose levels are high or you will get into a situation where you will give them potassium intoxication.

Q. But I thought you were asked specifically, Doctor, what do you do when you have a person who has a high digoxin reading and you said that this FAB was not available because it was developed in Boston, I think it is, and they will not provide you with the ingredients of it, but you said you give potassium.

A. You may give potassium if the level is normal or low.

Q. So, you are saying that you would have to check the potassium level before you --

A. Yes, sure.

Q. And that you just couldn't give it holus bolus if you knew that a person was --

A. No. That is a well-known caveat.

Q. The author then goes on and talks about serum electrolytes. He says:

"The serum electrolytes will monitor the serum sodium, potassium and bi-carbonate, all of which are vital concerns, particularly in patients



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who are receiving intravenous
fluid therapy."

Do you agree with that?

A. Yes.

Q. He says - and then he
talks about potassium:

"Potassium determination is even
more important as a low potassium
can cause muscle weakness and heart
failure. It is even more important
in any patient who is receiving
digoxin and may lead to dangerous
arrhythmias."

Do you agree with that?

A. And he says:

"A high potassium is also dangerous
as it can produce an irritable
myocardium and can lead to arrhythmia
and cardiac arrest."

A. Yes.

Q. Do you agree with that?

A. Yes.

Q. Now, Doctor, you gave
evidence, it seems a long time ago but it was actually,
I believe it was July 27th, Volume 17, when you were



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1
2 asked by Mr. Lamek, dealing with Kevin Pacsai, his
3 cause of death and, if I could refer you, Mr.
4 Commissioner, to page 2924 --

5 THE COMMISSIONER: The page?

6 MR. SHINEHOFT: 2924, line 22.

7 Q. You were asked:

8 "Were you prepared to accept that
9 the immediate cause of Kevin Pacsai's
10 death was digitalis toxicity?"

11 And you gave the evidence:

12 "We thought that most likely."

13 The Commissioner then says:

14 "I'm sorry, what was that?"

15 And then the witness, you, said:

16 "We thought that most likely at
17 the time."

18 Mr. Lamek then says, or asks the question:

19 "I'm sorry, Doctor, I am perhaps
20 not making myself clear. The
21 pathologist doesn't say the
22 immediate cause is most likely to
23 be and he doesn't say the immediate
24 cause may be. He says the immediate
25 cause of death is digitalis toxicity.
I want to know whether, at that time,



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at the time you obtained information
as to his view and his conclusion
and the information upon which his
conclusion was based, whether you
agreed with him."

And your answer was:

"We did."

Do you recall giving that evidence,
Doctor?

A. Yes, I do.

Q. And is that your evidence
today?

A. That's what we thought at
the time, yes.

Q. Okay.

Now, let me ask you this, Doctor.
When a person dies, you have indicated previously
that, for the most part when people die, the immediate
cause of death is their heart failure. Their heart
stops and then they die.

A. Yes.

Q. But you go beyond that and
you make investigations as to what caused that
heart failure; is that correct, Doctor?

A. Yes.



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Q. And you come to a conclusion and you call that conclusion a cause of death; is that correct?

A. Yes.

Q. And is it normal to have one cause of death or a number of causes of death as far as a particular child is concerned?

A. One major cause of death and perhaps some contributing causes.

Q. But it is normal, is it not, to have one major cause of death?

A. Yes.

Q. And dealing with the question of Kevin Pacsai, and you had his digoxin levels and you were aware of that.

A. Yes.

Q. And the Coroner was aware of that and he prepared a report. What conclusions did you come to as far as his cause of death?

A. We thought that was digoxin.

Q. And do you feel today that that is still correct?

A. I'm not sure.

Q. You're not sure. Why, Doctor, are you not sure?



Rowe
cr.ex. (Shindhof)

1
G22 2 A. Well, because of what dis-
3 cussion and knowledge has emerged about the behaviour
4 of digoxin in patients who are dying and who have
5 died.
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Q. Well, would you agree with me, Doctor, that the levels that were shown ante, the ante mortem level of greater than 10 and the postmortem level of 25.5 are toxic levels for digoxin?

A. Yes, I think so.

Q. And as a matter of fact the ante mortem is at least four times what you considered the normal, the maximum normal therapeutic level, is that not correct?

A. I don't know that I have ever said what I considered the maximum for therapeutic level.

Q. I thought the therapeutic level was .5 to 2.5?

A. That is what the guidelines say in the book, but I think I was at pains at various times to point out that I think you can have higher levels without any toxic effect.

Q. Yes, and you referred to as you look at the clinical effect?

A. Yes.

Q. Of the baby, and if it seems to be working, and it is helping the baby then you don't worry about the levels, is that correct?



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A. Yes.

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Q. But you wouldn't do that with
a level of 10, would you?

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A. No, certainly not.

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Q. And would you agree with me
that regardless of the maximum upper limit of the
therapeutic range, a level of 10 is certainly two,
three or maybe four times higher than the maximum
therapeutic rate?

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A. Twice at least.

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Q. At least twice?

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A. Yes.

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Q. As a matter of fact in your
evidence you indicated that it was unlikely, in your
opinion, that it was through an accidental administration,
is that not correct?

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A. Yes, I think we looked at that
question.

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Q. And you made a report and an
investigation?

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A. Yes.

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Q. And you came to the conclusion,
did you not ---

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A. That there was nothing wrong
with the administration.

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2 Q. That there was nothing wrong
3 with the administration. So are you not faced with
4 the situation that if the cause of death of this
5 baby were to be digitalis intoxication, that it would
6 have been as a result of a deliberate administration
7 of that drug?

8 A. I suppose it could also be
9 accidental, but I think a deliberate administration
10 is certainly the thing we thought of.

11 Q. Okay, and you are saying now
12 that you are not sure of the cause of death because
13 of certain reactions of digoxin, is that correct?

14 A. Yes. I think that I said in
15 relation to this child, that this child fits into a
16 group of half a dozen other babies where there is
17 reason for debate and examination by people who are
18 more expert in the interpretation of these levels than
19 I am.

20 Q. Well, I would like to under-
21 stand what you mean by interpretation of the levels,
22 especially when you garnered an antemortem sample.
23 I understand there is a question about the multiplier
24 effect after death. I understand there is the question
25 of tissue as opposed to blood. Here is a case where
you have a blood sample before death which had a toxic



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2 value attached to it. My question very simply, Doctor,
3 is how can you interpret other than what the coroner
4 said as far as his cause of death?

5 A. Well I think as I have said
6 before that is for others to give an opinion on. It
7 is an interpretive situation in a child who may be
8 dying and I don't know all the ins and outs of that,
9 I am not prepared to - I am only prepared to say that
10 our thought was that this baby had had an overdose of
digoxin.

11 Q. Yes.

12 A. And I have some reservations
13 about that now simply because of the knowledge that
14 has expanded in this area, and the people that you are
15 going to have to ask that question to are the
16 pharmacologists.

17 Q. So you are saying, Doctor,
18 that if the pharmacologists were to say that the cause
19 of death was digitalis toxicity that you would be
20 prepared to move this baby from the "may" of six
21 or seven to the "for sure" column that Justin Cook
is in?

22 A. Yes.

23 Q. And he is there alone, is that
24 correct?
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A. Yes, that is correct.

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Q. And that you feel you are

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not qualified to give an opinion as to whether he fits
in the "may" or "for sure" category?

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A. Yes.

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Q. Because you are just not an

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expert in that area?

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A. That is right.

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Q. Is there any other reason that

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you would suggest that Baby Pacsai, his death, may
have been from any other cause?

11

A. From any other cause?

12

Q. Yes.

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A. Than digoxin?

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Q. Yes.

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A. I think I am persuaded by the

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suggestions of Dr. Bain.

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Q. Okay. I would like to talk to

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you about the suggestions of Dr. Bain. Dr. Bain has
written a report, and on page 27 he talks about what
some doctors refer to as "transient hypofunction of
the adrenal cortex", is that right?

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A. Yes.

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Q. Have you got his report there?

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A. Yes I do.

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Q. Would you like a minute to
review the report?

A. No, you can go ahead.

Q. And you have indicated that
Dr. Bain is a paediatrician with the normal clinical
experience?

A. Yes.

Q. Is that a fair characterization
of Dr. Bain?

A. Yes.

Q. And is Dr. Bain an endochronologist?

A. He has spent a lot of his time
in endochronology.

Q. And would that be part of his
expertise?

A. Yes.

Q. Do you know Dr. Angus McMillan,
Dr. Rowe?

A. Yes.

Q. Is he a paediatrician?

A. Yes.

Q. Is he an endochronologist?

A. Yes.

Q. And is he involved in this type
of problem?



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A. I would think he probably is.

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Q. Dr. Bain in his report says,

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if I can refer, Mr. Commissioner, to page 27, about

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half way down, he says:

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"The diagnosis which immediately comes

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to mind is acute adrenal insufficiency.

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The commonest cause of this in Kevin's

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age group is the adrenogenital syndrome,

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but this was ruled out by the findings

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of normal size adrenal glands.

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The second cause is Addison's Disease,

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but again microscopic examination of the

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adrenals did not reveal such a condition.

However..."

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He goes on:

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"...transient adrenal insufficiency

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is a very well recognized syndrome in

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You have read that?

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A. Yes.

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Q. And do you agree with that?

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A. I don't know anything about that

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condition.

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Q. Well, if you didn't - but you

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did make comments to Mr. Lamek's questions as to the

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cause of this baby's death, did you not?

A. Yes.

Q. So are you saying that you have holus bolus relied on what Dr. Bain has said, and you are not prepared to qualify it or discuss it because you don't know about it, is that what you are saying?

A. I am not an expert in that area at all.

Q. Well, let me put forth to you a couple of positions and maybe Dr. Bain certainly will be the appropriate person to ask these questions. Let me ask you this. Dr. McMillan, who as you have indicated is a paediatrician and an endochronologist, has examined the medical charts of Kevin Pacsai, including the autopsy report, and he has indicated and I would like to discuss what he says...

MR. SCOTT: Well, is my friend going to produce a copy of what he says so we can see it?

MR. SHINEHOFT: I am going to examine Dr. Rowe about what he says, and I may very well be producing Dr. McMillan in person.

MR. SCOTT: Well it seems to me we should see his report.

THE COMMISSIONER: I think it would be helpful if we saw his report. I think it would, and if



1
2 you are going to do that sort of thing, you know the
3 way we have been conducting the examination. The
4 way to get expert opinion if you feel you must call
5 expert opinion, or perhaps suggest the names to Mr.
6 Lamek and maybe he will call him. I consider it an
7 odd way to do it to go out and seek a doctor and then
8 put this unless you intend to call him.

9 MR. SHINEHOFT: Subject to speaking to
10 my friend I certainly intend to ---

11 THE COMMISSIONER: Well, all right, read
12 to us what it is and perhaps we will be able to get
13 copies of this.

14 MR. SCOTT: I take it my friend will
15 provide copies for distribution, or Mr. Lamek.

16 THE COMMISSIONER: Mr. Lamek will do
17 it.

18 MR. SHINEHOFT: I have only brought my
19 own personal copy.

20 THE COMMISSIONER: Don't worry about
21 it, just read it, just let us have what it is he
22 says, unless it is very long. What is the particular
23 point that you are going to make?

24 MR. SHINEHOFT: Well there are several
25 points I would like to bring out.

THE COMMISSIONER: Let us have them one



1
2 at a time then.

3 MR. SHINEHOFT: Okay.

4 Q. Doctor, you were asked about
5 this type of condition and one of the questions that
6 you were asked was, and I refer to page 2947 of your
7 evidence, and at the bottom you said - I will read
8 starting at the bottom and it says:

9 "Now, Dr. Bain, as we know ---".

10 THE COMMISSIONER: What he says, what
11 Dr. Bain suggests is one of the causes was adrenal
12 insufficiency.

13 MR. SHINEHOFT: That's right.

14 THE COMMISSIONER: Is that what you want
15 to say?

16 MR. SHINEHOFT: Q. And then he goes on
17 the next page and he says:

18 "Is that a kind of condition into
19 which one can make some investigation
20 and arrive at some conclusion?"

21 And I believe your answer to that question is:

22 "A. Usually you can."

23 A. That was my understanding.

24 Q. Do you recall giving your
25 evidence yesterday, to Mr. Tobias, at page 4608.

THE COMMISSIONER: What volume is that?



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MR. SHINEHOFT: I am sorry, Mr. Commissioner, it is Volume 25.

THE COMMISSIONER: And the page?

MR. SHINEHOFT: 4608, Mr. Commissioner, line 15. Actually line 13 is the question, and it says:

"Q. All right. Then what is meant by the term 'transient'?

"A. 'Transient' means that it is possible that it might resolve because there is no disease to explain the adrenal abnormality. So, it may resolve. It is conceivable that a patient with that disease might resolve as compared to somebody who has adrenal pathology, if you like, say, a hemorrhage or something like that into the adrenal gland where you wouldn't normally get better. "Q. Now, is this something that would have specific characteristics on autopsy?

"A. No."

A. But you can have tests during life which would show disturbances.

MR. SCOTT: Would you put the next



question.

MR. SHINEHOFT: Well my friend has asked me to read the next question.

Q. And the next question:

"Q. All right. Would the finding on autopsy that the adrenal gland showed no anatomical abnormalities and no irregularity in size, would that necessarily rule out that theory?

"A. I understand not. You know, I'm not an expert in this."

Well, if I were to tell you, Doctor, that the quote from Dr. McMillan's report, if I can find it, on page 2 he says, and I am quoting:

"We are then left with the possibility that this was a transient hypofunction of the adrenal cortex. This condition is characterized by a number of the signs and symptoms of adrenal insufficiency accompanied by the usual laboratory findings of elevated potassium and decrease serum sodium. To my knowledge this condition can seldom be confirmed with the more complete picture of decreased serum sodium and elevated sodium potassium. Decreased



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"serum cortisol, increased ACTH,
increased plasma, renoactivity,
abnormal cortisol production and
secretion."

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He goes on to say:

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"I believe most of the children
presented with such a clinical picture
and who do not survive usually have
some anatomical abnormality of the
adrenal gland, either in size or
architecture."

12

Would you agree with that?

13

A. I am not competent to say.

14

15

Q. Would you agree that on
autopsy of Kevin Pacsai he had neither an abnormality
in size, nor an abnormality in architecture?

16

A. That is right.

17

18

Q. He had, to quote you, a
perfectly normal heart, did you not say that?

19

A. Yes.

20

21

Q. Now Dr. Bain also says that
this is a well recognized syndrome in this age group.
Are you familiar with that syndrome, Doctor?

22

23

24

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A. No, I have never seen that
syndrome at all, but you know, I have read the books,



1
2 since Dr. Bain's report, but I am not an expert on
3 this at all, I am a cardiologist.

4 Q. Again this may be more
5 appropriately a question to ask Dr. Bain.

6 THE COMMISSIONER: So far as you are
7 prepared to go, you have undertaken to call Dr. Bain?

8 MR. LAMEK: Yes I certainly intend to
9 call Dr. Bain.

10 THE COMMISSIONER: Dr. Rowe says he is
11 not an expert, but he has drawn the conclusion from -
12 please correct me if I am wrong, Dr. Rowe, but you have
13 drawn the conclusion from the reading of Dr. Bain's
14 report.

15 THE WITNESS: Yes.

16 THE COMMISSIONER: Is that right?

17 THE WITNESS: Yes.

18 THE COMMISSIONER: Isn't that right?

19 THE WITNESS: Yes.

20 THE COMMISSIONER: That is the whole
21 basis for it?

22 THE WITNESS: Yes and maybe reading
23 through the paediatric text.

24 THE COMMISSIONER: All right.

25 MR. SHINEHOFT: Q. If it were to be
shown, Dr. Rowe, that Dr. Bain was wrong in his



1
2 assessment of the situation, and his opinion, would
3 you agree that you were wrong?

4 THE COMMISSIONER: Yes, so would I if
5 that is of any help to you.

6 Mr. Scott might not, but everybody else
7 in the room would.

8 MR. SCOTT: Not until I had a count
9 to make sure everybody was against me.

10 MR. SHINEHOFT: Q. So you would
11 suggest I would assume that Dr. Bain would be the
12 proper person to discuss the various reports and the
13 opinions as to what exactly this particular malfunction
14 is?

15 A. Oh yes.

16 Q. And again you don't feel you
17 are qualified to really get into that?

18 A. No.

19 Q. What about potassium levels,
20 do you feel you are qualified to discuss the question
21 of potassium levels?

22 A. That is so intimately wrapped
23 up with that situation that I think you would get all
24 your answers in one session.

25 Q. I see, so you feel I would be
fragmenting my case if I were to ask you about the



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elevated potassium levels, Doctor?

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A. You might well be.

4

5

MR. SCOTT: I am just making a list
of things to warn Dr. Bain about, so you are tipping
your hand here.

6

7

8

MR. SHINEHOFT: Well we are here to
find out what happened, so perhaps Dr. Bain should know
in advance what he is going to have to face.

9

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Q. Just a couple of other questions,
Doctor, if I may. You had a couple of M and M
conferences in September of 1980 and then you went
away on a Sabbatical, is that correct?

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Q. And you went to New Zealand,
I believe?

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A. I went to Australia and
New Zealand.

6

7

Q. Australia and New Zealand.
And you left Dr. Jedeikin in charge, was he ---

8

9

A. No, Dr. Jedeikin was the
senior fellow of our training program, and he was
in charge of matters which fellows are involved in.

10

11

The person who would be in charge of
the department while I was away was Dr. Fowler.

12

13

Q. But you had left certain
responsibilities to Dr. Jedeikin, did you not?

14

15

16

A. Yes, I did.

17

18

19

Q. And one of those responsibili-
ties was to set up or organize or conduct a further
mortality conference?

20

21

22

A. Yes, that is true.

23

24

25

Q. And I believe you gave
evidence that this was not done?

A. That was not done.

Q. Did you ever find out why it
was not done?

A. Well, Dr. Jedeikin told me
that he was too occupied with other duties to perform



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that job.

3

Q. Did you find that strange,

4

that he ---

5

A. Well, I do not find that

6

strange because they are pretty stretched as a

7

staff group, but I did not accept it as the total
excuse.

8

Q. I am sorry, I did not hear

9

you. You did not accept ---

10

A. I did not accept it as a

11

complete excuse.

12

Q. I understand that you were

13

pretty upset when this happened?

14

A. I was.

15

Q. Is it normal that you would

16

give a direction to a fellow that would not be under-
taken?

17

A. No.

18

Q. Now, you were asked in Volume

19

15, page 2024, if I can refer you to that, Doctor.

20

THE COMMISSIONER: What did you say,

21

2000 and --- ?

22

MR. SHINEHOFT: 2024, Mr. Commissioner.

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THE COMMISSIONER: Volume 15?

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MR. SHINEHOFT: 2024, line 15.

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THE COMMISSIONER: The volume though?

MR. SHINEHOFT: Volume number --
I am sorry, Volume 12. I am sorry, I apologize,
Volume 12. It is line 15.

THE COMMISSIONER: 2054, line 15.

MR. SHINEHOFT: Q. You were asked
by Mr. Lamek at line 9 approximately:

"Q. But you had not yet, as I
understand you, you had not yet made
any association or attempted to discern
any association between nighttime
deaths and the presence of particular..."

THE COMMISSIONER: Sorry, I have
got the wrong page. What page is it?

MR. SHINEHOFT: 2024, Mr. Commissioner.

THE COMMISSIONER: Yes, all right.
Thank you, I have read that.

MR. SHINEHOFT: Q. "...attempted to
discern any association between night-
time deaths and the presence of
particular people, particular nursing
units, or other people on the wards,
residents on duty, that sort of thing?

A. No, because I think we all
recognized that you are going to have



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"a proportion of patients who die at night. Although we didn't have figures on that basis from the Hospital and remained for others to get those figures with their computers and other rather extensive efforts to put the times together for a large number of deaths, nevertheless we thought that one should expect a considerable proportion of patients to die at night."

Well, you were here, Doctor, were you not, for the evidence of Dr. Gilmour-Bryson?

A. Yes.

Q. You heard her evidence, her entire evidence?

A. Yes.

Q. And you heard her being asked at page 1589 ---

THE COMMISSIONER: Volume, please?

MR. SHINEHOFT: I believe it is Volume 10, Mr. Commissioner.

THE COMMISSIONER: 1000 --- ?

MR. SHINEHOFT: --- 589.

THE COMMISSIONER: All right.

MR. SHINEHOFT: Q. Just at the



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beginning it says:

"Q. In terms of your own work, have you taken any courses or done any work with respect to statistics?

A. Only computer statistics courses that as I took as an undergraduate, I do not prepare any applied statistics.

Q. You don't prepare any?

A. No, I do not ever prepare any applied statistics. Statistics courses are designed to teach you how to apply complicated interpretative statistics, probabilities and so on, which I do not engage in at all, all I am doing is very simple arithmetic."

And then further on it says:

"Q. I am just trying to be clear. You haven't applied statistics with respect to the work you have told us about this morning?

A. No, not unless you mean counting and dividing."

Doctor, could you not do the same counting and dividing that Dr. Gilmour-Bryson did?



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A. I expect we could, but
Dr. Gilmour-Bryson spent some time counting and
dividing, I believe.

I think my comment at that time was
that we were only shortly into this period and that
it seemed to us that the numbers at that stage were
not enormously out of kilter and that it was not our
perception of a need at that time.

Q. But you would agree with
Dr. Gilmour-Bryson that there were no complicated
statistics that had to be prepared or computers that
had to be engaged? It was simply a matter of simple
mathematics?

A. Yes.

Q. And that at the time those
figures were available to you?

A. You mean in July and August?

Q. Yes. Not what happened
subsequent but what happened up to July and August,
those figures were available to you, were they not?

A. Yes.

Q. But you failed to do the
calculations?

A. Yes, we did not do those.

Q. And did you ever do the



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calculation?

A. It was done by others.

Q. And have you since done
certain calculations?

A. Yes, we have done other
calculations, surely.

Q. So in retrospect, these things
are now very carefully monitored; is that right?

A. They are being done, yes.

Q. But they were not being done
at the time?

A. No.

MR. SCOTT: Mr. Commissioner, it
is almost lunch, but can I just try this again.

My friend acts for the parents of
Kevin Pacsai and we agree, I think everybody agrees
he should enquire as fully as he wants into any
causes for the death of Kevin Pacsai. Kevin Pacsai
died at 10 o'clock in the morning.

I mean, the issue of nighttime deaths
which is so relevant for some parents has no bearing
whatever in this particular case. Now, is my friend
insistent in going through it all on a case where it
has no ramifications for him at all.

MR. SHINEHOFT: Well, with all due



1
2 respect, Mr. Commissioner, I am not referring
3 specifically to nighttime deaths. It is my under-
4 standing Dr. Gilmour-Bryson did charts and provided
5 us information with many other things.

6 THE COMMISSIONER: Yes, just a minute
7 now, Mr. Shinehoft. The point that Mr. Scott is
8 raising is one that I have raised before, and that
9 is your main issue, your concern is the death of
10 Kevin Pacsai. It has to be, that is the one you
11 have to deal with.

12 Now, it is conceivable that there is
13 a relevancy sometimes in other issues that will assist
14 us in determining that, but you will be of far more
15 assistance to this Commission and to your clients if
16 you concentrate on that one death.

17 MR. SHINEHOFT: I appreciate that
18 and unfortunately the one area I wanted to discuss
19 with Dr. Rowe he feels he is not qualified to discuss.

20 THE COMMISSIONER: Well, you will
21 have an opportunity then with some other witness.

22 MR. SHINEHOFT: I certainly will.

23 Q. Let me ask you this: in regard
24 to Kevin Pacsai, could you restate for me what you
25 think the possible causes of his death are?

A. I think that the causes of



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death are either that he had this hypoadrenal situation which Dr. Bain I believe says that there is evidence for or he has had an overdose of digoxin.

Q. And are you prepared to concede this, Doctor, are you prepared to say that in your opinion it is unlikely that there are any other causes of death?

A. I think so.

MR. SHINEHOFT: I have no further questions, thank you.

THE COMMISSIONER: All right, thank you. We will rise now I guess until 2:30.

I do not know which of you gentlemen is going first?

MR. SCOTT: Well, I am prepared to go. I have got some unfinished business. I asked Dr. Rowe, you will recall, with respect to his 14 potential causes of death, to prepare a chart which shows which babies exhibited the symptoms that point to other causes of death. My friends really have not seen that because I have just got it, so I will be putting that in first with a chart, a real chart as opposed to a record, and that maybe they will want to ---

THE COMMISSIONER: Can you help us,



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I think it is really Mr. Lamek you are going to
help most by indicating how long you think you will
be?

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MR. SCOTT: I think I will be an hour
and a half.

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THE COMMISSIONER: And Mr. Ortved,
how long will you be?

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MR. ORTVED: I would think maybe 20
minutes.

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THE COMMISSIONER: Okay. Then until
2:30.

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---Luncheon recess.

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---Upon resuming at 2:30 p.m.

THE COMMISSIONER: Yes, Mr. Scott.

RE-EXAMINATION BY MR. SCOTT:

Q. Dr. Rowe, when you see me here again, I do not want you to get the impression that the whole thing begins over again and goes on and on until somebody confesses and then we go home. But I have the right to ask you some questions arising out of the questions that my friends have asked you.

First of all, when I examined you, you gave us 14 possible causes of death that would produce symptoms of the type that Mr. Lamek emphasized in his examination in chief. Do you recall that?

A. Yes, I do.

Q. And you did that for us, and then I asked you, and I think it was on a Friday I asked you if you could go over each of the files and determine the number of cases and the names of the patients in which symptoms other than heart failure were apparent, and were you able to do that?

A. Yes, I was.

Q. Now, let me give you -- I am showing you a three-page chart, and is that what you prepared? ~

A. Yes.



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Q. Yes. And I take it on the left hand are the names of the 36 babies with which we are concerned?

A. Yes.

Q. And across the top are the 14 symptoms that you and I discussed in your examination?

A. Yes.

Q. And I take it that the wider column is three types of conduction failure which I discussed as three headings and you have lumped them as one and then sub-divided them?

A. Yes.

Q. And again, what does a plus mean?

A. A plus means that that was present in that patient.

Q. And when you say it was present in the patient, are you referring to the record that is an exhibit here?

A. Yes, I am.

Q. Yes. And would it be correct to say that if it was present in the patient that that would amount to evidence from which you might, not must, but might conclude that that was either



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caused or contributed to the cause of death?

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A. Yes.

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Q. Now, zero means of course

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that it was not present in the record?

6

A. That is correct.

7

Q. Now, you always do something

8

here to confound me, and I notice that on the third
page under Velasquez there is a plus in brackets.

9

MR. PERCIVAL: Mr. Commissioner, I

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hate to be obstreperous, but how does this arise out
of questions?

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MR. SCOTT: It does not arise. It

13

is something I promised to do and did not do.

14

THE COMMISSIONER: I know,

15

Mr. Percival, this is going to be a terrible

16

disappointment to you, but I do not concern myself

17

as much as I should with that sort of problem, but

18

I will certainly give you the opportunity to cross-

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examination with further re-examination if we

absolutely have to.

20

MR. PERCIVAL: I understand, but

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it is like a ping-pong match, as you can well

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appreciate, Mr. Commissioner. I know that this good

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witness is going to be back again and I just ---

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THE COMMISSIONER: What?

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MR. PERCIVAL: Well, I am told by
Mr. Lamek on other matters and I may reserve my
rights on that.

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THE COMMISSIONER: I think that
Dr. Rowe would have some cause for complaint. Are
you serious?

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MR. LAMEK: I tried to keep it a
secret from him.

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THE COMMISSIONER: Well, I think that
is a shock and if you do not come, the chances of
your getting into trouble with the law are pretty
slim.

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MR. PERCIVAL: Mr. Commissioner, I
make the point because I had not heard anything of
this coming out in cross-examination, and when I have
not been here I have studiously avoided considering
the matter but I have looked at the transcripts and
still nothing has come out of this.

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THE COMMISSIONER: Well, I am going
to allow him to go on and I will bear in mind your
rights and your complaint.

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MR. PERCIVAL: Thank you.

MR. SCOTT: If Mr. Lamek is going
to keep secrets, if he could keep a secret where
these hearings are held so Mr. Percival would not



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come so often it would be a help. We have had two
useful and productive days.

4

Q. Now, Dr. Rowe, what does the
plus in brackets mean?

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A. Well, I put that bracket
around that patient because it was a symptom that
existed on admission of the patient but was not
predominant at the end.

9

Q. That was not ---

10

A. That was not predominant at
the end.

11

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MR. SCOTT: I see. Now, could I
ask that that sheet, Mr. Commissioner, be the next
exhibit.

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14

THE COMMISSIONER: Yes.

15

THE REGISTRAR: 158.

16

THE COMMISSIONER: 158.

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---EXHIBIT NO. 158: Three-page document entitled
"Certain Clinical Variables
in 36 Ward Related Deaths".

19

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MR. SCOTT: Q. Now, Dr. Rowe, I
asked you if you could have someone in the Hospital
present initially for my benefit, because it is
easier to understand, two charts, and have you done
that?

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A. Yes, I have.

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Q. And can we take the chart

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first of all that has the brown border on it, and

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will you describe to the Commission, it is perhaps

6

obvious, but just describe what that is. First

7

of all, is it based on this exhibit?

8

A. Yes, it is.

9

Q. And compiled in the same way?

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A. Yes.

11

Q. Yes.

12

A. Along the horizontal axis on

13

this chart is listed the 14 features that have been

14

referred to by Mr. Scott. The vertical axis indicates

15

the numbers of patients who had that variable. Thus,

16

if you are looking at the number who were suffering

17

from hypoxia at some point, then the number would

18

be 15.

19

Q. And from that would we conclude

20

that in 15 of these 36 deaths there was evidence of

21

hypoxia from which you might conclude that hypoxia was

22

the cause or related to the cause of death?

23

A. Yes.

24

MR. SCOTT: Could I ask that that

25

be the next exhibit.

THE COMMISSIONER: Yes, 159.



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We are not going to have, I take it,
little copies of that or are we? You do not have to.

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MR. SCOTT: I think we do. Our
idea is just to cover my friends with paper.

6

7

MR. PERCIVAL: I thought I was the
only one that thought that.

8

9

MR. SCOTT: Paper will not do for
my friend Mr. Percival.

10

11

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Q. Now, the next chart has a
green border, and will you describe to the Commission--
well, first of all, is that again based on the previous
exhibit which you have just introduced this afternoon?

13

A. Yes, it is.

14

Q. And compiled in the same way?

15

A. Yes.

16

Q. And will you tell the
Commission what it shows?

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A. It just adds up the number of
these different variables that exist for each patient
and then it lists the number of patients with one,
two, three, four or more variables.

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Q. So would I be correct to say,
for example, looking at the third column that there
were 14 of the 36 patients who exhibited three
variables?



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A. Yes.

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Q. And I take it that there were no patients who merely had evidence of one method of dying?

6

A. Right.

7

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Q. Now, just so we will be clear, did you also prepare a sheet that sets out the definition of the variables as they are found on the previous exhibit?

10

A. Yes, I did, and that is it.

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MR. SCOTT: And perhaps,

Mr. Commissioner, it can be really marked -- it should have been part of the ---

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THE COMMISSIONER: Well, I do not think we have marked the other one. This latest chart is 160 and we will make this 160A, is that what you are saying?

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MR. SCOTT: Well, it should really be 158A because it goes with the paper chart.

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---EXHIBIT NO. 158A: Document entitled "Definition of Variables".

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THE COMMISSIONER: And then the green bordered chart is 160 and have we copies of that?



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2

MR. SCOTT: We have circulated them.

3

THE COMMISSIONER: I am sorry, am

4

I wrong?

5

MR. SCOTT: You get to keep the

6

originals.

7

THE COMMISSIONER: I have got 159

8

as the brown bordered one, is that right, and I have
got 158 as the -- the green one we have not got yet.

9

I beg your pardon, I am sorry, you did give us two.

10

I thought they were the same thing. So this will

11

be 159 and this one will be 160, yes, all right, we

12

have that then. I have got it the other way around.

13

The green one -- we have done it

14

backwards from the way you introduced it. The brown

15

chart is 160 and the green chart is 159. Is that

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going to disturb you?

17

MR. SCOTT: No, sir.

18

THE COMMISSIONER: Well, that is

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good. Then we will mark this "Definition of Variables"
as 158A.

20

---EXHIBIT NO. 159:

Document entitled "Number of
Variables Per Patient in 36
Ward-Related Deaths".

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---EXHIBIT NO. 160:

Document entitled "Number of
Each Variable Present in 36
Ward-Related Deaths".

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MR. SCOTT: Q. And I take it,

Dr. Rowe, for example, in those cases on the green chart where you have three variables for 14 patients, does that mean that in the case of those patients there would be evidence on the record that would reveal that there were three potential causes of death?

A. Of those variables, yes.

Q. Yes. And that therefore in ascertaining the cause of death, your function is to take the record and any clinical observations that may not be disclosed in the record that you have and select one or more of those causes as the probable cause?

A. Yes.

Q. Now, I am going to come to the matter of SIDS very shortly, but are you familiar with some of the material that has been prepared on SIDS in the journals?

A. Yes, I am.

Q. And first of all, we might as well deal with it now, are you familiar with a two part review called "SIDS and Near SIDS" which appeared in the New England Journal of Medicine in 1982?

A. Yes.



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Q. Yes. Now, I will making this an Exhibit in due course, but just to start off, I want to read you one sentence in this study and ask you if you agree with it and I can tell you that the doctors writing the article are speaking of children as a group and here is what they say:

"Most deaths in the first year after the neonatal period occur suddenly and unexpectedly."

Is that consistent with your experience and, insofar as you know, the experience of other cardiologists?

A. Yes.

Q. Yes.

THE COMMISSIONER: I'm sorry, could you read that again. Most deaths... ?

MR. SCOTT:

"Most deaths in the first year after the neonatal period occur suddenly and unexpectedly."

Now, I take it, Dr. Rowe, that that doesn't tell you anything about the cause of the deaths, does it?

A. No.

Q. It simply tells you about the



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manner of dying.

A. Yes.

Q. So, would your experience be in dealing, as this author is, with babies under one year that most of their deaths, however caused, are sudden and unexpected?

A. Yes.

Q. Yes. But you have to try and ascertain a cause, if you can?

A. Yes.

Q. Is the method of their dying, that is, suddenly and unexpectedly, of any particular assistance in ascertaining the cause?

A. No.

Q. Well, let me go further. If, of the 36 babies, 11 died suddenly and unexpectedly, or 23 died suddenly and unexpectedly, or two died suddenly or unexpectedly, as a doctor, would that convey anything of significance to you when you come to assess the cause of their death?

A. Only their age, only the fact that they are babies.

Q. Yes. Now, is that view, insofar as you are aware, shared by other expert paediatricians?

A. I believe so.



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Q. Yes. Well now, let's come to
SIDS. First of all, I want to refer you again to this
article and two other articles. Are you familiar
with an article by Marie A. Valdes-Dapena, M.D.
called "The Sudden Infant Death Syndrome -- A Review
of the Medical Literature 1974 - 1979"?

A. Yes, she writes regularly on
this topic.

Q. Yes. And she has written in
Paediatrics, Volume 66 of October 1980.

A. Yes.

Q. Yes. And are you familiar with
an article by Richard L. Naeye, N-a-e-y-e, called
"Sudden Infant Death", and I am unable to tell you
where it was reported?

A. It was probably in The
Hospital or something like that.

Q. Take a look at the article,
first of all, and we will find out where it was
reported later and tell me if you are familiar with
the article.

A. Yes.

Q. All right. Now, let me read
you some passages.

THE COMMISSIONER: I wonder, do we



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want to make these exhibits or not?

MR. SCOTT: Yes. As I only have one copy at this stage, can we mark them shortly, sir?

THE COMMISSIONER: Yes, all right.

MR. SCOTT: Q. Let me read you one passage from the Naeye article:

"One of the most devastating things that can happen to parents is to lose a baby to the Sudden Infant Death Syndrome, where an infant who had seemed to be in good health is found dead in its crib. The phenomena, which is also known by its initials, SIDS, is defined clinically as the sudden, unexpected death of an apparently healthy infant, for whom a routine autopsy fails to identify the cause of death.

It is often called crib death or cot death, since it usually happens when the baby is sleeping." Now, are you familiar with those observations and do you agree with them?

A. Yes.

Q. Yes. Going on from the



BB5

article:

"In the U.S., it kills about 7,000 infants per year, or about one out of every 500 babies born, making it the most frequent cause of death between the ages of one month and one year. It is also a common cause of death in many other countries."

Now, do you accept that opinion as your own?

A. Yes.

Q. Yes. Going on, the author says:

"For years, it has been almost totally mistifying to physicians. Now however, as a result of an intense interdisciplinary effort over the past eight years, promising clues to the Syndrome have been obtained. They hold out the hope that potential victims can eventually be identified and that steps could be taken to save them."

Are you generally familiar with the research that has been done to find a cause for the



BB6

phenomena Sudden Infant Death?

A. Yes, broadly speaking.

Q. Yes. Now, the author here reviews the potential causes, and I am not going to take you all through them, but I want to ask you about some of his observations. He says:

"Until 1972, the most widely held hypothesis attributed the deaths to an abrupt closure of the upper air-way that occurred without preliminary symptoms."

Now, you were a doctor in 1972, was that a view that was becoming common then?

A. Yes.

Q. Yes. Then he goes on to say this:

"Epidemiological investigations... ", a word which we are all going to have to learn how to pronounce by late November,

"... Epidemiological investigations made before 1972 had revealed some unusual features of this Syndrome that are not easily explained by a sudden closure of the air-way or by most of the other notions about



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"Sudden Infant Death that were entertained before 1972. The deaths have a distinctive age distribution. They do not take place in the period shortly after birth, appearing first among babies who are two or three weeks old reaching a peak at three months of age and then decreasing in frequency until they become rare after the first year of life. Most of the hypotheses advanced before 1972 also failed to explain why most of the victims die while they are asleep." Would you agree with those

observations?

A. Yes.

Q. And then the author comes on to deal with some new views of the cause:

"The underventilation that reduces the level of oxygen in the pulmonary air spaces also lowers the level of oxygen in the arterial blood that circulates through the rest of the body. This deficiency of oxygen in the blood is termed hypoxemia. Its



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"consequences are found in more than half of the victims of the Sudden Infant Death Syndrome. The first of the consequences to be discovered was an abnormal retention of brown fat." Do you agree with that observation?

A. Yes.

Q. Yes. And then he goes on:

"With some many signs of under-ventilation before death in these babies, one is moved to look for a reason. There is evidence to indicate that the underventilation is the result of abnormalities in the mechanisms that control respiration. Prolonged episodes of apnea during sleep in babies that later fell victim to Sudden Death Syndrome have been observed."

Then he gives a whole lot of what lawyers call cases but which I think you call articles. This evidence suggests that the babies had abnormalities in the control centres of the brain stem that normally respond to accumulation of carbon dioxide by increasing the frequency in death of breathing, and I



1
2 take it there, he is referring to apnea as a cause or
3 a potential cause of SIDS?

4 A. Yes.

5 Q. And what today is regarded as
6 the most likely cause of the Sudden Infant Death
7 Syndrome?

8 A. I think the current view is
9 that there is a defect of some sort in their
10 respiratory centre.

11 Q. Yes. And does that cause
12 apnea?

13 A. Yes.

14 Q. Yes. So, how does apnea rank
15 as a cause of Sudden Infant Death?

16 A. Very high.

17 Q. Yes.

18 THE COMMISSIONER: I don't want those
19 to get away without being marked.

20 MR. SCOTT: No, no, no.

21 Q. And then he goes on to say this,
22 and I'm not reading, I am summarizing and the article
23 will be the test, that if the breathing stops in the
24 case of a child, unlike an adult, it may be extremely
25 difficult to get it started again. Is that an
observation you have about babies?



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A. Yes.

3

Q. Then he says:

4

"Sudden Death babies who have these..."

5

He has been talking about carotid bodies,

6

"... under developed carotid bodies

7

also show at postmortem examination

8

the signs of chronic underventilation

9

and hypoxemia I have described."

10

Now, if you will turn to the Hines

11

baby. Is there any evidence in the record that that
baby suffered from either apnea or hypoxemia?

12

A. Yes.

13

Q. And can you tell the

14

Commission, without going to the record, how

15

extensive the evidence of apnea is?

16

A. Well, it dates from the home

17

and is repeated in the North York Hospital and is
repeated in the Hospital for Sick Children.

18

Q. Yes. And to what cause of

19

death does that apnea point, in the case of the Hines
baby?

20

21

A. It points to Sudden Infant

22

Death Syndrome.

23

Q. Yes. Is there any evidence of

24

any other cause of death of parallel significance in

25



1
2 the case of the Hines baby?

3 A. No.

4 Q. No. Now, could I make, Mr.
5 Commissioner, the two-part article by Daniel C.
6 Shannon, M.D., and Dorothy H. Kelly the next exhibit,
7 and I think it can be one exhibit.

8 THE COMMISSIONER: Exhibit 161.

9 ---EXHIBIT NO. 161: Two-part article by Daniel C.
Shannon and Dorothy H. Kelly.

10 MR. SCOTT: I will try to get copies
11 for my friends.

12 And can I make Dr. Valdes-Dapena
13 article in Paediatrics, called SIDS -- A Review of
14 the Medical Literature, the next exhibit?

15 THE COMMISSIONER: Exhibit 162.

16 ---EXHIBIT NO. 162: Article entitled "The Sudden
17 Infant Death Syndrome -- A Review
18 of the Medical Literature 1974 -
19 1979" by Marie A. Valdes-Dapena.

20 MR. SCOTT: And last, the article by
21 Richard L. Naeye, "Sudden Infant Death" in a periodical
22 the name of which I will obtain for you, Mr.
23 Commissioner, as the next exhibit.

24 THE COMMISSIONER: Exhibit 163.

25 ---EXHIBIT NO. 163: Article by Richard L. Naeye,
entitled "Sudden Infant Death".

MR. SCOTT: Q. And now, I should just



1
2 read you, in the Dapena article, Dr. Dapena says
3 this:

4 "If all the articles that have been
5 written about Sudden Infant Death
6 Syndrome in the last five years could
7 be gathered together in one place,
8 counted and divided according to topic,
9 it seems probable that the greatest
10 number would have something to do with
11 apnea or hypoxia or both."

12 Do you agree with that, from your
13 study of the literature?

14 A. Yes.

15 Q. Now, leaving aside the
16 conclusion that the Commissioner may or may not draw
17 at the end of the case that there was a murderer in
18 this hospital, leaving that aside, is there any
19 evidence in the case of Baby Hines that points to any
20 other cause of death and now that you have had the
21 record and done your review?

22 A. Nothing other than the data
23 that's been advanced subsequent to the death.

24 Q. All right, thank you.

25 Now, just one matter about nursing.
If there was a problem in the cardiac wards that



1
2 related to the competence of a nurse or the competence
3 of a team which you did not personally observe, what
4 is the routine, or what was the routine at the
5 relevant time under which that complaint or concern
6 would be brought to your attention?

7 A. I think that would be handled
8 by nursing in the first instance, but I would imagine
9 that I would be informed by the head nurse at some
10 point.

11 Q. Would it come to you then
12 generally from the head nurse?

13 A. I would have thought so. I
14 suppose it might come from higher up than the nursing
15 ladder, but I would have expected that the head nurse
16 would have something to say to me.

17 Q. All right. But would the
18 complaint come to you from the nursing chain of
19 command?

20 A. Yes, it would.

21 Q. Yes. And if you, when you were
22 a young doctor, had a complaint about a nurse, as to
23 her competence or her ability or her service, to whom
24 would you be expected to make that complaint,
25 particularly in Sick Children's Hospital?

A. Oh, I think to the head nurse.



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Q. Yes. And now, during this period of time, was it ever brought to your attention, and the period of time I am talking about is from July to March?

A. Yes.

Q. The period?

A. Yes.

Q. Did anybody in nursing, of seniority, ever bring to you, or to your attention, a complaint about any nurse or any team?

A. No, I don't believe so.

Q. No.

THE COMMISSIONER: I'm sorry, you said I don't... ?

THE WITNESS: I don't believe so.

MR. SCOTT: Q. Was there any complaint about an individual nurse or about a team that you received from any other source before the police arrived?

A. No.

Q. Was there any evidence then or now, of which you are aware, that points to incompetence or unsatisfactory performance on the part of any nurse or any team, leaving out the police investigation?

A. No.



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3 Q. One matter I would like to
4 raise with you, and again, it has to do with Jordan
5 Hines. In the preliminary autopsy report, which is,
6 of course, under date March 8th, 1981, and we know
7 what that means, at page 28, and perhaps I can show
8 you mine, Doctor, to save you getting out yours. I
9 just want to read a bit from the last paragraph:

10 "The lungs showed congestion and
11 edema and, of interest, fibrous
12 thickening of the pulmonary arteriols,
13 suggesting chronic hypoxia... "

14 Well, we have heard about that.

15 "... persistence of brown fat was also
16 seen in the autopsy... "

17 We've heard about that.

18 "... the brain showed gliosis in the
19 brain stem in the region of the dorsal
20 vagal nuclei."

21 Am I pronouncing these words right?

22 A. Yes.

23 Q. Vagal nuclei, how am I doing?

24 A. Very well.

25 Q. All right.

"This is the finding seen in SIDS."

A. Yes.



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Q. "Other findings which support a diagnosis of a missed SIDS are the persistent **extramedullary** hematopoiesis, the persistence of brown fat and the thickening of the pulmonary arteriols.

The pathological evidence, in conjunction with the clinical history, makes the diagnosis of a missed SIDS a possibility."

And I take it, stopping at that point, the autopsy is going in the direction of SIDS?

A. Yes.

Q. Then the author says:

"However, this does not explain the arrhythmias and further conclusions will have to await examination of the conducting system."

Now, I want you to look at Dr. Shannon and Kelly's two-part article, which is already an exhibit, in part one, page 963, dealing with SIDS under the heading:

"Cardiovascular Factors."

The author says this:

"Arrhythmias account for a small number of cases of SIDS and recent



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"evidence from babies with near-SIDS suggests an alternation in control of the heart rate."

Now, stopping right there, is that consistent with your observations?

A. Yes.

Q. So that the person doing the autopsy thinks that the presence of arrhythmia contraindicates SIDS, what is your view?

A. I don't think it does.

Q. And does the article appear to sustain your views?

A. Yes.

Q. Now, let me come to coroners and the matter of coroners because Mr. Hunt asked you a number of questions about those. I take it that long before these events in March of 1980, the Hospital for Sick Children had an on-going relationship with the local coroner and the coroner's office?

A. Yes.

Q. Yes. And that relationship arose out of an unlimited number of contacts, as doctors or pathologists would make reports by telephone to the coroner and as the coroner would accept or reject the case or come in and investigate.



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Q. You have already told us
that every cardiac case which results in the death
is discussed at the morning conference, and one
issue dealt with there is whether or not the
Coroner should be called.

A. Whether the Coroner was
called or not, yes.

Q. And if he wasn't called, is
there discussion sometimes as to whether he should be?

A. It might be.

Q. Now, you have already agreed
with the statement in the article that most of the
deaths of babies under one year or sudden and un-
expected.

A. Yes.

Q. And I take it that was the
experience in your Hospital?

A. Yes, it was.

Q. Now, "sudden and unexpected"
happens to be a phrase that is used as well in the
Coroner's Act, which Mr. Hunt brought home to you.

A. Yes.

Q. Now, I take it it is obvious
that the Hospital was not, in this period, reporting
every death that was sudden and unexpected in a



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2 medical sense because that would be most of the
3 deaths?

4 A. Yes.

5 Q. Had the practice that
6 existed about the kind of deaths you reported to
7 the Coroner, was the practice that existed in March
8 1980 the practice that had existed during your time
9 in the Hospital?

10 A. Yes.

11 Q. And was there any under-
12 standing between the Hospital and the Coroner's
13 office of which you were aware as to how you would
14 judge which of most of the deaths you were to report?

15 Now, leave aside cases where you
16 thought there might be negligence or something like
17 that, or malfeasance, because I think you told us
18 earlier that you would report those.

19 A. Yes.

20 Q. Apart from that, what was
21 the understanding as to whether it was reportable
22 from the Coroner's and the Hospital's point of view?

23 A. Well, we took it that patients
24 for whom there is a very obvious and easily explain-
25 able cause for the death on a medical basis was the
type that would not require reporting.



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THE COMMISSIONER: I'm sorry, what was that again?

THE WITNESS: We took it that the patients who had very obvious medical causes for their condition and death would not require reporting in that category.

MR. SCOTT: Q. Was that known to the Coroner's office before March 1980?

A. I don't know, but I presume it must have been.

Q. And in order to determine the cause of death, did you make what Mr. Hunt called your internal judgment?

A. Yes.

Q. And I take it that, in making your internal judgment, you looked at the clinical symptoms --

A. Yes.

Q. -- you looked at the record --

A. Yes.

Q. -- you looked at an autopsy, if there was one?

A. Yes.

Q. And did you look at any other evidence of tests and so on that might come to your



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CC4 2 attention?
3 A. Whatever was available.
4 Q. And I take it that any
5 doctor in that process or, indeed, I think any
6 nurse, was entitled on their own to make a report
7 if they didn't agree with the cause of death assigned?
8 A. Yes.
9 THE COMMISSIONER: I am a little
10 doubtful it happened very often.
11 MR. SCOTT: Well, it may not.
12 THE COMMISSIONER: Once in a while,
13 perhaps.
14 MR. SCOTT: I raise this matter
15 which has to do with events after the epidemic
16 period because of the nature of Mr. Hunt's cross-
17 examination.
18 Q. Did the Hospital staff, or
19 some of you, have a meeting at grand rounds with
20 Dr. King?
21 A. Yes.
22 Q. And who is Dr. King?
23 A. I understand he is the
24 Deputy Coroner, or somebody very high in the Coroner's
25 office.
Q. What was he there for?



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A. He was there to explain when
to call the Coroner.

Q. Can you tell us when that
grand rounds was?

A. I can't remember exactly.

Q. Can you get the date for me?

A. I think I can.

MR. SCOTT: And I will produce it
to the Inquiry.

Q. Can you tell us what he told
you after these events about when Hospital people
should call the Coroner when you are having deaths,
most of which would be sudden and unexpected, accord-
ing to this article?

A. Well, the question came up
again about the judgment factor. My understanding
was that we were asked to use judgment on this matter.

Q. What was the judgment you
expected to make?

A. The judgment as to whether to
call the Coroner because of the nature of that phrase,
"sudden and unexpected".

Q. But what judgment were you
expected to make? What cases would you call and which
cases wouldn't you call, according to Dr. King?



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A. Well, he kept it fairly broad. He didn't make specifics, as I recall it.

Q. Well now, did you have a meeting with the Coroner and others to discuss some cardiac deaths in September of 1982?

A. We did.

Q. And I take it that was because, in 1982, there was a doubling of the number of deaths in the ICU?

A. That is correct.

Q. For a period - not nine months, but for a substantial period, you had, in the ICU in 1982, a graph that looked at these like the first part of the graph for the epidemic period.

A. Yes.

Q. And as a result of that, I take it that you had a meeting with some Coroner's officials.

A. We did.

Q. And I want to show you the minutes of that meeting, which I believe took place on September 7, 1982 in the Pediatric Conference Room. I want to ask you - leave out the handwritten notes - whether the typed portion appear to be the minutes of that meeting?



Rowe
re.ex. (Scott)

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A. Yes, it does appear to be.

3

Q. And was Dr. Tepperman there?

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A. Dr. Tepperman was there.

5

Q. And in those notes, there

6

are a number of babies discussed. Then, at page 3,
there is this exchange:

7

"Dr. King..."

8

Who is Dr. King at this meeting?

9

A. He was another Coroner.

10

Q. He was another Coroner?

11

A. Yes.

12

Q. "Dr. King was asked whether

13

there was always a need to inform

14

the Coroner. He replied that the

15

decision to inform the Coroner was

16

the judgment call on the part of the

17

physician but if any doubt existed,

18

the Coroner's office should be

19

informed."

20

Did he say that?

21

A. Yes.

22

Q. Did he say it was a judgment

call the physician was to make?

23

A. Yes, I believe so.

24

Q. Then:

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Hospital?

A. Yes.

Q. Were you making internal judgment calls to the best of your ability during the epidemic period?

A. Yes.

Q. And were those internal judgment calls based on the evidence available at death, or shortly after, as best you can assess it?

A. Yes.

Q. And was the practice that Dr. Tepperman refers to in September 1982, in which he reiterates that an internal judgment call should be made before the Coroner is called, was that the practice as long as you have been in the Hospital?

A. Yes, as long as I can recall.

Q. And were there cases where the Coroner simply refused to accept the assignment?

A. Yes, there are.

Q. And looking back on it, Dr. Rowe, not from the point of view of what we know about the police investigation, but looking back on it, let's say up until March 1st, in the period from July to March, can you think of any cases where you think you would have made a different internal



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judgment as to whether the Coroner should be called,
knowing what you knew then and up until, say, early
March?

A. No, I don't think so. I was
trying to think whether Estrella might be one of
those, but I think my view on Estrella was it was a
borderline question.

Q. Apart from Estrella, is there
any other case?

A. No, I don't think so.

MR. SCOTT: I think I will tender
this memorandum as the next exhibit, if I may.

--- EXHIBIT NO. 164: Minutes of meeting, September 7,
1982, held in Pediatrics
Conference Room.

MR. SCOTT: Q. In order to make an
internal -- let me put it this way: Mr. Hunt, I won't
say he criticized the Hospital but the emphasis in
his questions was that, instead of making your own
investigation, you should have called the Coroner
right off.

In order to make an internal
investigation, or an internal judgment, do you have to
make an investigation?

A. Yes, you do.

Q. And what may that involve?



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Everything through autopsy?

A. Yes.

Q. Now, have you made enquiries about what happened in the Dawson case with respect to the Coroner?

A. Yes.

Q. Can you tell us whether the Coroner was called there?

A. Yes, I believe he was.

Q. Who called him?

A. I believe he was called by Dr. Schaffer, the Fellow in Cardiology.

Q. And what do you understand happened?

A. I think that the Coroner decided this was not a case for his consideration.

THE COMMISSIONER: Can you tell us why you think -- Is this speculation or is this what somebody told you?

THE WITNESS: No, it is written down somewhere, I think, or maybe it isn't; maybe Dr. Olley told me that.

MR. SCOTT: I guess we will probably be having Dr. Olley, so we might as well just leave it.



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THE COMMISSIONER: I don't want it to become cumbersome; I don't want you to call everybody whose name is dropped at this hearing.

MR. SCOTT: No. Have I done enough to get Dr. Tepperman in?

THE COMMISSIONER: I hope not but probably you have.

MR. SCOTT: Q. But I take it that, in any event, if the Coroner was called, the investigation was done by the Hospital?

A. I think that the Coroner initially didn't take the case but, then, my understanding is that because the mother of this youngster was personally concerned about the death, Dr. Peter Olley then called the Coroner himself, and the Coroner subsequently did take the case.

Q. Now, let's talk --

THE COMMISSIONER: Is this still the Dawson case?

MR. SCOTT: Yes.

Q. Let's take another example where one of the three where you called the Coroner, Velasquez, did the Coroner initially agree to take up that case?

A. No.



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Q. Why not?

A. I am not sure why not.

Q. But, in any event, he didn't
take it up?

A. No.

Q. Did something later appear
about it in the newspapers?

A. Yes.

Q. Then, what happened with
respect to the Coroner? I'm sorry, I should
interrupt you. When the Coroner decided not to take
up the case, did the Hospital investigate the
death as best it could?

A. Yes, we did. We looked into
that ourselves, yes.

Q. And I think we have already
heard your explanation at that time for that death -
an idiosyncratic drug reaction?

A. Yes.

Q. Now, did the Coroner, after
that, take up the case?

A. Yes, he did.

Q. And I think we have his
death certificate in the file, do we not?

A. Yes, I believe it is.



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Q. And he rejects idiosyncratic drug reaction because he sets out that the death is unexplained.

A. Yes.

Q. Now, that was the Coroner's view but are you aware whether the Coroner called an inquest in respect to the Velasquez death?

A. No, he did not.

Q. Are you aware whether he did any other investigation?

A. I don't know.

Q. Now, let's just deal with this one more point. Do I have it right that, following death, the major investigative tool that isn't forensic is an autopsy?

A. Yes.

Q. And if you were investigating a death, you would want an autopsy?

A. Yes.

Q. And I take it that if a Coroner, a medical doctor, wanted to investigate the death, leaving aside any forensic techniques he may have, he would want an autopsy?

A. Yes.

Q. Is it not true that you do,



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at Sick Children's, your Pathology Department does
all the autopsies for the Coroner's Department?

A. All the pediatric autopsies.

Q. All the pediatric autopsies?

A. I think so.

Q. And is that so for the
entire Province of Ontario?

A. I don't know.

Q. Is it so for Metropolitan
Toronto?

A. I think it is.

Q. So that, if the autopsy is
a major investigative medical tool, whether you call
the Coroner or not, the autopsy in Metropolitan
Toronto for a pediatric death is going to be done in
your Hospital?

A. I think that must always,
most always be the case.

Q. Has that always been the case?

A. I think there are times when
it has been done outside but that must be infrequent.

Q. Now, when a pathologist
does an autopsy, apart from examining the physical
remains, does he review the chart as well?

A. Yes.



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Q. Do pathologists at the Hospital for Sick Children have some training in medical/legal matters?

A. Oh, yes.

Q. If they find any --

THE COMMISSIONER: When you talk about that, it is the same with the chart - you are just absolutely sure you are talking about Hospital records?

THE WITNESS: The Hospital record, yes.

MR. SCOTT: I'm sorry, yes, Mr. Commissioner.

THE COMMISSIONER: I think almost any five-year old child would have known, under the circumstances, that is true, but I thought perhaps I hadn't reason to that level yet!

MR. SCOTT: I am getting very good at it. I got a note from Miss Cronk that said "chart" and I didn't know what she was talking about.

Q. I take it, when the pathologist has done the autopsy and looked at the record, he is perfectly entitled to phone the Coroner if he wants to?

A. Oh, yes.



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Q. And they frequently do?

A. They have done that, I believe.

THE COMMISSIONER: Would you like to take a break now, Mr. Scott? Would that help you?

MR. SCOTT: I think I can finish up.

THE COMMISSIONER: No, no, that's fine. I thought you were considering your position.

MR. SCOTT: No. I think I have just got two questions.

Q. At page 4253 --

THE COMMISSIONER: The volume?

MR. SCOTT: Q. -- Volume 23, you were dealing with the death of Baby Miller, and Mr. Hunt was asking you about it, and you say, and I will just read it:

"MR. HUNT: Q. Is it your understanding that Miller was reported to the Coroner immediately upon Miller's death?"

"A. I thought that had been done, yes."

"Q. At what time, do you know?"

"A. I do not know what time, but I thought it had been done by Dr.



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Fowler."

"Q. All right. Then it is your understanding, although you have no precise recollection of it, that by the time you went into the meeting with the Coroner, the Coroner had taken charge of that investigation?"

"A. Well, I do not know. I presume that that should have been the case."

"Q. And that is because of the circumstances that were prevailing at the time of death?"

"A. Yes."

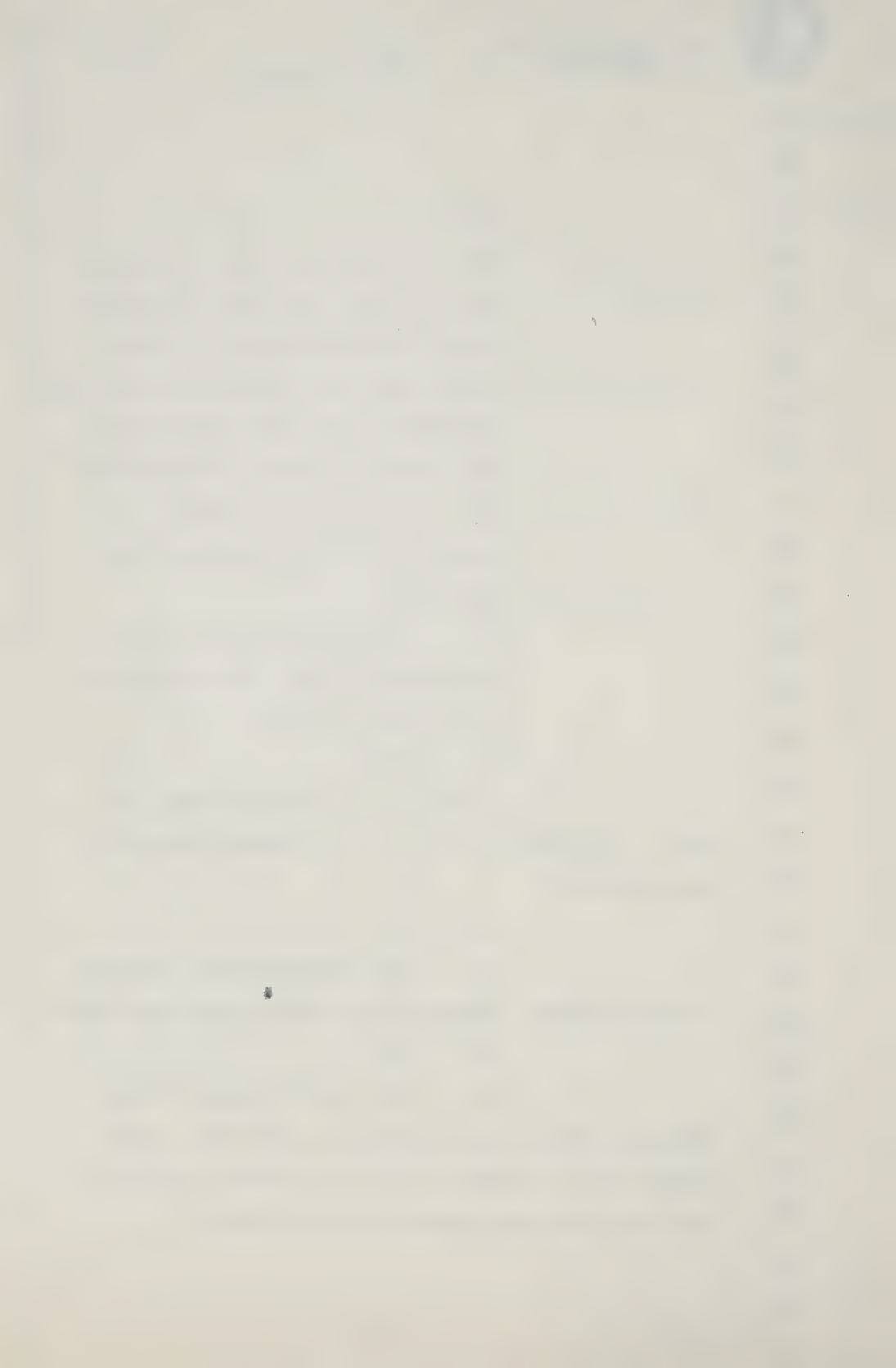
I want to ask you about that, Dr. Rowe. Was Baby Miller one of the babies whose body was autopsied?

A. Yes.

Q. And I take it that, as part of that autopsy, digoxin post mortem tests were done?

A. Yes.

Q. Now, at the moment of Baby Miller's death, were you able, or does the record enable you to conclude from the evidence available when she died the probable cause of death?





Rowe
re.ex. (Scott)

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A. I think I previously testified that I thought it was heart failure.

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Q. Now, at the moment of her death, therefore, from the record, is there any evidence or cause for which you should call the Coroner?

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A. No. Strictly speaking, there isn't.

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Q. Now, we know that some hours later, I am not quite certain how many hours later, the digoxin serum postmortem readings were done; is that correct?

A. Yes.

Q. And was the coroner called after that?

A. Yes.

Q. So when you said to Mr. Hunt, "I presume that that should have been the case", that is, that you should have called the coroner right after Baby Miller died, is that correct or is it not correct?

A. Well, it is using a bit of hindsight, I think.

Q. All right. What is the fact in the Miller case that would have made it a coroner's case in your opinion?

A. The finding of the level of digoxin in the blood.

Q. All right. Now, I am going to leave the rest to Mr. Ortved, but I should tell you that I was away in Ottawa last week and I picked up the Globe and Mail and I was reading with interest and pleasure of the proceedings of this Inquiry and



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happy not to be there for a week, and I read that you had said in response to a question from Mr. Percival that if the officers had been called after Miller died, police officers, Baby Cook might have been saved.

Now, you will not be interested in my reaction to that.

MR. LAMEK: That is not what the evidence was.

MR. SCOTT: Q. The evidence is at page 4274. It begins on page 4273, and the reason I ask it is that this series of questions put by Mr. Percival must have come as a very great shock to the parents of that dead baby, because what is said here, you were being asked, you will recall, whether you had discussed the death of the Baby Miller at the meeting in the coroner's office on that Saturday afternoon; do you recall that?

A. Yes.

Q. And you said that you did not believe you discussed it with the police officers?

A. I could not remember.

Q. You could not remember?

A. Yes.

THE COMMISSIONER: Well, there seems to be a problem about that.



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MR. LAMEK: He said it must have
been mentioned; he would be surprised if it was not.

MR. SCOTT: Q. I am sorry, yes,
Mr. Lamek is quite right.

All right, let us go back to line 11:

"Q. All right. And in your evidence
already you have seemed to indicate
that you don't know, or you don't
remember whether the death of Baby
Miller was in fact discussed at that
meeting with the coroner and the police
officers?

A. Yes.

Q. And did you say you would be
surprised if you didn't?

A. Yes.

Q. The fact that you would be
surprised would be - is that it followed
the same pattern, didn't it?

A. Yes."

And Mr. Lamek is right, you say there you would be
surprised if it would not be discussed, and
Mr. Percival comes on:

"Q. If both of the police officers
that were present at that meeting in



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2 "the Coroner's Office in the afternoon
3 of Saturday, March 21st, categorically
4 denied that either you or any of your
5 other physicians at the Hospital in
6 any way, shape or form mentioned the
7 death of Allana Miller, are you in a
8 position to disagree?

9 A. No.

10 Q. That would be terribly sur-
11 prising, wouldn't it?

12 A. Yes.

13 Q. If not shocking?

14 A. Yes."

15 And then this question:

16 "Q. Because had you told the
17 officers maybe something else could
18 have been done, might have even saved
19 Baby Cook that night?

20 A. Yes. I'm not sure when I
21 first learned about the ---

22 Q. I understand that.

23 A. Yes.

24 Q. But if they say you didn't.

25 A. Or that Dr. Fowler didn't?

Q. Nobody did.



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"A. I see. Well, that's ---

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Q. Is bad, eh?

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A. Yes.

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MR. PERCIVAL: May I end on that?"

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Now, I concluded from that that you were being asked to agree that if you had notified the police officers, this Baby Cook might have been saved by something that the police officers would do.

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Now, what I want to ask you, and I am going to ask Mr. Ortved who is prepared to follow it up, is do you know whether the coroner was notified?

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A. Of the level?

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Q. Of the Miller death?

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A. Of the Miller death?

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Q. And the level?

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A. Yes, he was.

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Q. Yes. Do you have any information as to whether the coroner notified the police?

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A. I understand that he did.

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Q. Yes.

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MR. PERCIVAL: When?

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MR. SCOTT: Do you want to know when?

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Six hours before the baby died. It is a scandalous assertion to make which is completely unsupported, and I am going to leave it right there.

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MR. PERCIVAL: Mr. Commissioner, with all due respect, it is not fair. Let us not talk about information. Let us know what this Doctor says and knows.

THE COMMISSIONER: I think it is reasonable, Mr. Scott, that you should ask what information he does have and perhaps also to say from where he obtained that information.

MR. SCOTT: The information will come as no surprise to Mr. Percival who asked the question, because it is in the preliminary inquiry.

THE COMMISSIONER: All right. I do not want this to degenerate. Could we just ask Dr. Rowe, if we can, what he knows, if he knows where that information -- where he got the information and what the time was and who was notified. Can you help us on that, Dr. Rowe, and if you cannot you cannot, but if you can, can you tell us?

MR. SCOTT: Well, I can read in the transcripts. That is what I was going to do.

THE COMMISSIONER: Well then, that I think should come as a statement from you, not as a question to the witness.

MR. SCOTT: All right.

THE COMMISSIONER: And I do not



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object to your making the statement. I think it is quite proper to make it, but it does not help as much to put the question to Dr. Rowe, who does not apparently know. Do I correctly state that?

THE WITNESS: I only know second-hand throughout. I was not there.

THE COMMISSIONER: Well, second-hand does not seem to worry us much at this stage. If you know, do you know from anyone other than Mr. Scott, that is all I wanted to know.

THE WITNESS: Yes.

THE COMMISSIONER: All right, well, tell us what do you know.

THE WITNESS: Well, my understanding from Dr. Fowler and Dr. Carver ---

THE COMMISSIONER: Is what?

THE WITNESS: --- is that the coroner was notified about the level and that he ---

THE COMMISSIONER: About the level. At what time would this be?

THE WITNESS: I think it was about 8:30 or some time like that.

THE COMMISSIONER: 8:30 p.m. on the 21st?

THE WITNESS: On the Saturday evening.



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THE COMMISSIONER: On the 21st then.

THE WITNESS: That he came into the Hospital around 11:00 or -- 11:00 p.m. or some time of that nature. I cannot remember the exact time and that he was informed, he went over material with them and that my understanding was ---

THE COMMISSIONER: At which time -- wait a minute, I am sorry, but I have got at the moment that the coroner was informed at 8:30 p.m. about the death and about the levels?

THE WITNESS: About the death and the levels.

THE COMMISSIONER: Yes, all right. And the coroner came in about 11:30?

THE WITNESS: I think it was 11 o'clock. I cannot remember exactly, but it certainly was that evening and it was after an interval of time.

THE COMMISSIONER: Yes.

MR. SCOTT: I can take Dr. Rowe all through it, but I think Mr. Ortved is better prepared to do that. The point I want to make is that the question advanced by Mr. Percival who acts for the police was based on the assumption that the police did not know about Miller's death before Baby Cook died, and if they had known as he says in his



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questioning, maybe Baby Cook could have been saved.

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The fact is that at the preliminary inquiry the evidence was called by the Crown, and I presume prepared by the police officers in the sense that they were in charge of the case which note of it will be forthcoming, which made perfectly clear that the coroner was notified as soon as the results of the serum reading were available and that he said he would notify the police forthwith.

THE COMMISSIONER: That certainly is valuable information to have and valuable evidence to have. It still is not, though, what Mr. Percival was complaining about. He was complaining about there was a meeting with the police officers and at that time no mention was made of the Miller death. That is all.

MR. SCOTT: No, Mr. Commissioner, that is not --- With the greatest respect, that is the factual basis upon which he makes it, and we have no complaint about that. As Mr. Lamek has said, there are two answers on that. Dr. Rowe begins by saying I am certain someone must have said it, it seems likely, and Mr. Percival says, well, if two police officers deny that it was mentioned at the



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3 meeting, would you disagree with them, and he said
4 no, he would not disagree with them. That takes care
5 of the afternoon meeting. No trouble with any of
6 that.

7 Then Mr. Percival says:

8 "Q. Because had you told the
9 officers maybe something else could
10 have been done, might have even saved
11 Baby Cook that night?"

12 THE COMMISSIONER: Well, this is very
13 appropriate re-examination, then, what you have said.
14 All I can say is that there is nothing wrong with
15 the question. The question was were you or did you
16 or did you not inform -- Dr. Rowe does not conceive
17 he did not, but he says that if the police officers
18 say that he did not, it is quite possible that that
19 is so at that time. Now you have brought out the
20 fact that Dr. Rowe believes that the coroner was
21 informed at 8 o'clock and at 11:30 that night he was
22 there and of course the Cook baby did not die until
23 4 o'clock or 5 o'clock in the morning.

24 MR. SCOTT: With the greatest respect,
25 sir, there is something wrong with that question.
These matters get reported, and what is wrong with
that question, what is wrong with that question is



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that Mr. Percival's clients knew that before Baby Cook died that previous evening, they and the coroner had been notified of his serum reading, and yet the question was put as if they did not know about it. Now, I do not blame Mr. Percival for that, but I say that that is what is wrong with that question. It is an improper question. No one knew it and I am going to ask Mr. Ortved ---

THE COMMISSIONER: Well, the most you can say is it is an improper question without a follow-up. There is nothing wrong with the question. Perhaps it is the observation. Anyway, I certainly have your point. I understand and it is valuable information to have.

MR. SCOTT: All right.

THE COMMISSIONER: Now, Mr. Ortved, could we take a pause before we take you?

MR. ORTVED: By all means.

THE COMMISSIONER: All right, 15 minutes.

---Short recess.

---Upon resuming.

THE COMMISSIONER: Yes, Mr. Ortved?

MR. SCOTT: Mr. Commissioner, I should say that I have some questions about the



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investigation that took place apropos of some questions that Mr. Percival asked about co-operating with the police. I regard those questions as appropriately in part two of this Inquiry, but I would not like you or anybody else to think that my refusal to cross-examine is indicated by any other reason.

THE COMMISSIONER: You want to hold them off?

MR. SCOTT: Yes, until we get to part two.

THE COMMISSIONER: All right, very well. Mr. Ortved?

MR. ORTVED: Thank you, Mr. Commissioner.

RE-EXAMINATION BY MR. ORTVED:

Q. Dr. Rowe, I just want to follow up on some of Mr. Scott's questions in relation to the chronology of the weekend of March 21st and 22nd. In particular, I just want to ask you once again whether having regard to your view of the Miller child at the time of her death, whether or not that was a reportable case as far as you are concerned?

A. No, I do not really think it



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was. I think the events of that weekend have coloured my comments on it in a sense that I thought it had been notified at that time, but in fact I do not think the actual mode of death was of a nature that ordinarily would require reporting to the coroner.

Q. And insofar as a postmortem digoxin test was concerned, is it your information one was ordered in relation to Baby Miller?

A. Yes.

Q. And are you able to assist us as to why that would have been done?

A. I think that was done after discussion between Dr. Costigan and Dr. Fowler. That relates to I think the information about Pacsai.

Q. That is the information that was current as of the morning of March 21, 1981, the day that Baby Miller died?

A. Yes.

Q. And that is similarly the situation that was to be discussed at the meeting with the Coroner at 2:30 that afternoon?

A. Yes.

Q. And as of the actual time of that meeting at 2:30 in the afternoon, was there



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anything insofar as you or Dr. Fowler, or for that matter, Dr. Carver were concerned vis-a-vis Baby Miller that made it something suspicious to report to the police at that time?

A. I am not sure that at that time it was. As I have said, I think my comments on that are related to the rush of events over the weekend and the information after the time. Looking back on it afterwards I think that perhaps one might say that it would have perhaps been helpful to have had that information earlier.

Q. All right, but looking at it in the context of your meeting on March 21, 1981, was it simply another one of a number of deaths which had been experienced up to that date?

A. Yes.

Q. Not as at that point in time in the category of Estrella and Pacsai, namely, with elevated postmortem digoxin levels?

A. No.

Q. Then, coming to that meeting with the Coroner, and as I understand it, present were at the very least Dr. Bennett and Dr. Teperman, the police officers, Staff Sergeant Press, Sergeant Warr and yourself, Dr. Fowler and Dr. Carver, correct?



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A. Yes.

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Q. Among others?

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A. Among others.

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Q. And at that meeting, certainly

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one of the subjects that was discussed was the possibility of murder, right?

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A. Yes.

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Q. I take it it was that the

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meeting went forward at that point in time on the basis that there were still babies in Wards 4A/B

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being treated?

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A. Yes.

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Q. And as a result of that

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meeting on Saturday afternoon, March 21, when was it

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your understanding that the police were going to come

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into the Hospital and commence their investigation?

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A. I believe it was Monday, the

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following Monday.

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Q. Monday, March 23?

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A. Yes.

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Q. Now, is it your understanding

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that the digoxin test that was being run on -- well, let me ask you firstly this.

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If a digoxin level were to be requested,

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a postmortem digoxin level were to be requested on

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a Saturday, when in the ordinary course of events
would that level be done?

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A. Probably on the Monday.

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Q. All right. And is it your
understanding that that process was expedited, having
regard to the events that transpired at this meeting
with Dr. Bennett on Saturday afternoon?

9

A. I think that is correct, yes.

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Q. I would just like to read you
an excerpt from the evidence of Dr. Carver given at
the preliminary inquiry, and this is to be found in
Volume 27 of the transcript of evidence, page number 7.
This is on examination in chief by the Crown Attorney.
Dr. Carver was asked as follows.

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MR. PERCIVAL: Mr. Commissioner, was
Dr. Rowe there when Dr. Carver gave the evidence or
has he ever been given that information? I mean,
we are opening the doors to untold things, but that
is not even hearsay. It is a question of here it is,
do you agree.

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22

MR. ORTVED: Well, I intend to read
the evidence to him and ask him a question based upon
it.

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THE COMMISSIONER: Well, I cannot
disagree with what Mr. Percival says. The only thing



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I can do is rule against him in your favour for no other reason than it is faster, but Mr. Percival, I promise you I can understand. I have been around long enough that I know this is not evidence in any strict sense at all.

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MR. SCOTT: Perhaps Mr. Percival can help us by telling us if the two police officers were there when this evidence was given.

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THE COMMISSIONER: Yes, well, perhaps he can.

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MR. SCOTT: It seems to me that he might have something to say about that in view of the fact they were instructing him last Tuesday.

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THE COMMISSIONER: Yes, all right. It is getting to the end of a long day. Go ahead.

23

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MR. ORTVED: If Mr. Scott and Mr. Percival would just step outside, maybe we could get through this.

MR. LAMEK: My running is on Percival.

MR. SCOTT: I am ready. The fact that Lamek's money is on Percival makes me feel even better about it.

MR. ORTVED: Q. Question by the Crown Attorney:



1
2
3 "Q. What happened after that
4 meeting?"

5 Answer by Dr. Carver:

6 "A. When I left the meeting I
7 returned to the Hospital on Saturday
8 afternoon and met with the chief
9 resident, Dr. Costigan, and he informed
10 me that another child had died on the
11 same ward, a child by the name of
12 Miller. I requested that immediately
13 a digoxin level be run on that child's
14 blood and that was mid-afternoon."

15 Now, how does that accord with your understanding of
16 the chronology of events?

17 A. Well, I understood that
18 Dr. Costigan approached the pathologists to get the
19 sample at 9:30 or some time like that in the morning.

20 Q. Right.

21 A. To explain that he wanted
22 that sample. So if it had been taken and done in the
23 laboratory at that time, the result would have been
24 back by about 2:00 or so, I would say.

25 Q. But in the ordinary course,
would the laboratory be running postmortem digoxin
assays on a Saturday or a Saturday afternoon?



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OD19

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A. No.

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Q. And what would be the effect
of Dr. Carver's order that that be done immediately?

5

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A. I think they probably got
somebody in to do it.

7

8

Q. Right. And then, what is
your understanding as to when that result was received?

9

10

A. I think the level came back
at 8 o'clock or somewhere around that time. I cannot
remember whether it was 8:00 or 8:30.

11

12

THE COMMISSIONER: That is in the
afternoon?

13

MR. ORTVED: Q. 8:30 p.m.?

14

A. . 8:30 p.m.

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Q. And Mr. Scott could not
resist getting into this area, but what then
transpired insofar as your understanding of the
events is concerned?

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A. Well, it was reported to me
by Dr. Fowler that he called Dr. Teperman at 8:45.
I am not sure whether he called him before 8:45, but
he got a call back from Dr. Teperman in response to
his call at around that time, 8:45, I believe.

23

24

Q. Were you advised of this
result as well?

25



OD20

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A. Yes, I was.

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Q. Do you recall the approximate
time that you received the advice?

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A. I think it was when they got
the level.

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Q. And if I can just return to
the answer by Dr. Carver on the same page, he continues
his answer:

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"Around 8 o'clock that evening I was
called and told that the child also
had a high level of digoxin. I
requested that the coroner's office
be immediately informed. We went back
to the Hospital and had a meeting
with Dr. Fowler. The nursing supervisor
and the coroner came in and we discussed
taking immediate steps with respect to
having digoxin as a controlled drug,
being dealt with as a narcotic, being
locked up, having two nurses sign off
for the appropriate amount so that the
safety factor could come in on that.
Also at that time a decision was made
to do an inventory on the digoxin in
the medication cabinets on the wards



DD21

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"Throughout the Hospital and also to
examine the crash carts used in
emergencies as to their containing
digoxin."

Now just having regard to that passage, how does that
accord with your understanding of the chronology?

A. That sounds right on.

Q. So can you assist us as to
the reaction on the part of the physicians in the
Hospital when they learned of the result insofar as
Baby Miller was concerned?



EE.1
BmB.jc 1

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Q Well, I think they were very concerned that this was an obvious digitalis overdose and having regard to those steps which Dr. Carver indicated in his response were undertaken, were you involved in that action?

A. No

Q Were you provided with a memorandum concerning the steps that were taken on that occasion?

A. Yes.

Q And I don't think that has been tendered as an exhibit yet, but can you identify this particular memorandum?

A. Yes.

Q And when did you receive a copy of that?

THE COMMISSIONER: Could we ask him whose memo it is?

MR. ORTVED: Q Whose memorandum is it, Dr. Rowe?

A. It is from Dr. Carver.

Q And when did you receive it?

A. I think I probably received it on Monday.

Q All right. And does that set



EE.2

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out in some greater detail those measures undertaken
in consequence of learning of the Miller result on
that Saturday evening, March 21?

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A. Yes, it does.

5

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Q. And if I can just read it,
Mr. Commissioner, because I don't have copies to
distribute. It is entitled "Confidential",

7

8

Saturday, March 21, 1981 at 2225 hours, that would
be 10:25 p.m., is that correct?

9

10

A. Yes.

11

12

Q. "1. All digitalis will become
a controlled drug immediately and
treated as a narcotic; all digitalis
preparations in the Hospital will
be locked in the narcotics cabinet."

13

14

15

Can we find this somewhere? I think
this is in the Statement of Facts, is it not, somewhere?

16

17

MR. ORTVED: It may be.

18

THE COMMISSIONER: Well, you go ahead.

19

MR. ORTVED: All right.

20

Q. Well, it then goes on to enumerate
those actions that were taken, including having
digitalis dispensed by team leaders and signed for by
a second nurse.

21

22

23

THE COMMISSIONER: It is on page 92 of
the Statement of Facts.

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EE.3

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MR. ORTVED: All right, so it is.

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Q And it concludes with the

4

paragraph:

5

"Dr. Fowler has informed the coroner concerning the findings of a digitalis level of 72 in Allana Miller. A request has been made by way of Dr. Fowler for the heart preparations of those children who died on 4 A/B to be examined for digitalis levels. Extractions will be attempted."

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Maybe that could be the next exhibit.

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THE COMMISSIONER: All right, Exhibit

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165.

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--- EXHIBIT NO. 165: Memo from Dr. Carver,
March 21, 1981.

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MR. ORTVED: Q Now, what time is it your understanding Dr. Teperman, the Coroner, came to the Hospital in response to the information communicated to him concerning this level on Allana Miller?

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A I had thought he had come in at about 11 o'clock at night.

22

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Q And what is your understanding as to whether he notified his superiors in the coroner's office?

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A. I understood that he had called them.

Q. And what is your understanding as to whether or not the police were advised?

A. I understand the police were advised from them.

Q. And what is your understanding as to whether as of 11 p.m. on Saturday night, March 21, the police knew as much and the coroner's office knew as much about the events concerning Allana Miller as the doctors?

MR. PERCIVAL: I don't know how he can answer that, with respect.

THE COMMISSIONER: Well, I think it would be pretty hard to answer it, I must say, but I don't know.

MR. ORTVED: Well, was it your understanding that as of 11 p.m. ---

THE COMMISSIONER: Much of his understanding has come from his investigations since as to what had happened and what went on. So, if you're asking him what his understanding was - why don't you ask him what his understanding was at that time or his understanding now.

MR. ORTVED: Well, I am asking him



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about his understanding as of the next day or Monday, March 23, which is when it certainly would have been very much in the forefront of his mind.

THE COMMISSIONER: Well, Monday March 23rd, of course, the police would have known all about it by this time. I don't think there has been any suggestions that they didn't. The only suggestion was that perhaps they weren't informed early enough on the 21st, that's all.

MR. ORTVED: That's right, and my question is as to whether they were informed of the readings insofar as Allana Miller was concerned at 11 p.m. and the action undertaken by the Hospital as of 11 p.m. on Saturday, March 21.

THE COMMISSIONER: Well, do you know that, Dr. Rowe?

THE WITNESS: The only thing I know for certain is that I met the police officers on Sunday morning, later in the morning.

MR. ORTVED: Q And what is your understanding as to whether they were aware of the reading insofar as Allana Miller was concerned?

A. Well, I'm not sure exactly. I only have the information that comes from Dr. Carver and Dr. Fowler about that.



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Q All right. Well, let me just read you a portion from Dr. Teperman's evidence.

THE COMMISSIONER: Well, let's have his information first before we go to what Dr. Teperman said. What is your information?

THE WITNESS: My information is from Dr. Fowler and from Dr. Carver.

THE COMMISSIONER: And what did they say?

THE WITNESS: That they had informed Dr. Teperman and that he had rung the appropriate ...

THE COMMISSIONER: Yes, all right.

MR. ORTVED: Q And when had that taken place?

A That had taken place they thought at 11 o'clock at night or somewhere around that time.

Q On March 21, 1981?

A Yes.

Q Now, just on that topic, what is your understanding as to whether the police had come into the Hospital prior to your meeting them on the Sunday morning?

A I don't believe they had come in.

Q Now, just let me go to the



EE.7

1
2 evidence of Dr. Teperman at the preliminary inquiry
3 and that is to be found at Volume 26, page 32, and
4 he is asked these questions by the Crown Attorney
5 and gives these answers:

6 "Q. All right, what happened after
7 that?

8 "A. Um, the conclusion of that
9 meeting was that the Homicide would
10 begin a review of the situation
11 beginning March 23rd, that was the
12 Monday. The meeting was the Saturday
13 and they were going to come into the
14 Hospital on the following Monday. At
15 8:45 p.m. of March 21st I received a
16 telephone call from my answering
17 service to call Dr. Fowler. I called
18 him and he informed me that another
19 child had died early in the morning of
20 March 21st, 1981 by the name of Allana
21 Miller under strikingly similar
22 circumstances as the other two and that
23 a postmortem digoxin level had just
24 been reported to him in the range of
25 72 nanograms per millilitre.

"He told me at that point he was just



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"going into a meeting at Sick Children's Hospital with other members of the medical and nursing staff to discuss their heightened concern and their plans for the future.

"I came to the Hospital at 11 p.m. that night and reviewed Allana Miller's chart. The thing that became apparent at that time was that all three deaths occurred within the same time framework and at that point with the same nursing team.

"I called Dr. Bennett from the Hospital to inform him of this third death and he said he would call Staff Sergeant Press to inform him of this third death."

Now, if I can just stop there. Firstly, how does that accord with your understanding of the chronology?

A. That accords well.

(2)

Q. And just dealing with

Dr. Teperman's statement in his evidence to the effect that at that point the thing that became apparent at that time was that all three deaths



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occurred within the same time framework and at that point with the same nursing team, what is your understanding whether any communication in that regard was made to any of the physicians at the Hospital?

A. No information of that sort was given to me and I don't know about whether it was given to Dr. Carver or to Dr. Fowler. They didn't say anything to me about it if they did.

Q. Now, regarding Justin Cook. That child, as we have been over before, died at 4:56 a.m., Sunday, March 22, 1981, is that correct?

A. Yes.

Q. That is approximately six hours after Dr. Teperman, the Coroner, attended at the Hospital?

A. Yes.

Q. And approximately eight hours after the first advice to the coroner's office concerning the elevated dig. level in respect of Allana Miller, correct?

A. Yes.

Q. Do you know whether in consequence of Dr. Teperman's attendance at the Hospital and any communication ---

THE COMMISSIONER: Could I just



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interrupt for a moment? The Teperman evidence, I do not have that immediately before me. There are three deaths he is referring to. It is obviously Miller and Cook, but what is the other one, the third one?

MR. SCOTT: No, it is not Cook.

MR. ORTVED: No, it is Estrella, Pacsai and Miller.

THE COMMISSIONER: Oh, it is Estrella, Pacsai and Miller, all right.

MR. ORTVED: Q Now, can you assist me as to whether in consequence of Dr. Teperman's attendance at the Hospital on the evening of March 21st and any communication he had with either his superiors or through his superiors with the police, whether there was any additional suggestions as to other matters that might be undertaken by the Hospital or the staff other than those which had been undertaken and are set out in the memorandum just filed as the most recent exhibit?

A. I'm not aware of any on the Sunday. I think there was some more instituted on the Monday.

Q All right. What about on the Saturday night specifically?

A. No, I don't think so.



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Q Now, another point that may be of some importance is in terms of the preservation of evidence. Are you aware as to whether or not the preservation of evidence is something that can assist the authorities in an investigation?

A. Yes, I am.

Q And is preserving a scene and preserving items of evidence something which you as a physician are familiar?

A. I have become very familiar with it.

Q Were you familiar with it as of the night of March 21, 1981?

A. No.

THE COMMISSIONER: You are not a fan of "whodunits", I take it?

THE WITNESS: No, I'm not.

MR. ORTVED: Q And then just by way of completing the chronology, Dr. Teperman is then asked, and it is in the same volume, the next page:

"Q All right, and what happened after that?

"A. At 5:30 in the morning of March 22nd I got a call at home from Dr. Fowler. He just wanted to inform me



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"about a fourth death that occurred by the name of Justin Cook. He said that this occurred within the same time framework as the other three and in the same room as Allana Miller had died the previous night. He didn't feel that this case was related because the terminal event in this baby was very different. This baby had suffered some seizures and had a different cardiac problem than the other three and because of the particular problem this baby had digoxin would have been contra-indicated. The other three were on digoxin and this baby wasn't because digoxin may have been fatal if given to this child. He advised me that they had obtained blood samples and just as a matter of course would be checking for digoxin and other substances.

"At that point I advised him to keep me informed of the developments relating to the blood results.

"Q Did you learn anything about the nursing team?



EE.13

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"A. No, not at that time.

3

"Q. All right.

4

"A. Um, just shortly after that,

5

Staff Sergeant Press called to return

6

the call from the previous night. I

7

advised him of Allana Miller's death

8

and suggested that his investigation

9

should start that day rather than

10

waiting for their, what was to be a

11

routine inquiry the subsequent day,

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and arrangements were made to the

13

Homicide Squad to have a place at

14

Sick Children's Hospital that day to

15

begin their investigation."

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And you say that you then went to the

17

Hospital and met with the officers that morning,

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March 22. Is that correct?

19

A. Yes, I understand that is

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correct.

21

Q. Now, just to complete the matter

22

of Justin Cook regarding some of Mr. Hunt's position,

23

vis-a-vis the coroner, what is your understanding as

24

to whether or not the coroner was advised of the

25

death of Justin Cook?

A. He was notified immediately, I

believe.



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Q All right. And we know from the chart that for instance insofar as Justin Cook was concerned there was consent given but for a partial autopsy only, is that right?

A Yes.

Q And can you assist me as to whether Justin Cook was even accepted as a coroner's case as of March 22, 1981, the day of his death?

A I'm not sure.

Q All right. Can you assist me as to whether or not the Coroner, Dr. Teperman, ordered an autopsy as far as Baby Cook was concerned that day?

A I'm not sure. I don't know whether he ordered it. I think we got the permission for a limited autopsy.

Q Right. And do you know whether Dr. Teperman went beyond that and asked for a complete autopsy?

A No, I don't think he did.

Q All right. And in fact, where did the body go after leaving the Hospital for Sick Children?

A It went to Owen Sound.

Q Without an autopsy other than the partial autopsy?



EE.15

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A. Just the partial autopsy.

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Q. Just a couple of brief matters,

4

Dr. Rowe. Insofar as Mr. Shanahan's cross-examination today is concerned regarding Baby Lombardo, he asked you about that baby's course in the ICU. Do you recall those questions?

7

A. Yes, he did.

8

Q. And you gave him to understand

9

your impression of that child. Do I understand

10

correctly that since that cross-examination you have

11

been provided with an additional page that was missing from the Court copy of that exhibit?

12

A. Yes.

13

MR. SHANAHAN: I might say, Mr.

14

Commissioner, too for the record so it doesn't appear that my cross-examination was in any way meant to overlook or deceive the Doctor, but I too only, only after the conclusion of my cross-examination, got a missing page.

18

19

THE COMMISSIONER: Yes, all right,

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thank you. What exhibit is this one that it can be attached to?

21

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MR. ORTVED: I have it noted on my notes, Mr. Commissioner.

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THE COMMISSIONER: Yes, all right.

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EE.16

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MR. ORTVED: That is Exhibit No. 78 and the additional page that I have provided to Dr. Rowe, as I stand it, should be inserted between pages numbered 38 and 39 of that Hospital record.

THE COMMISSIONER: Between?

MR. ORTVED: Between pages 38 and 39, Mr. Commissioner.

THE COMMISSIONER: Well, I'm going to make it, so I won't forget to do that, between 38 and 39. What happened to the new page, did you give it to us?

MR. ORTVED: I certainly gave one to Dr. Rowe.

THE COMMISSIONER: Yes, but you didn't give one to us.

MR. ORTVED: I'm sorry.

THE COMMISSIONER: Well, I think we will make it 78A.

--- EXHIBIT NO. 78A: Missing page from Exhibit 78 to be inserted between pages 38 and 39.

MR. LAMEK: Mr. Commissioner, while you have that record open, I understand there are certain other pages also missing, three pages from the biochemistry record. The omission of these pages is in the way of a test to see who is reading carefully.



EE.17

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THE COMMISSIONER: Yes, all right.

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MR. LAMEK: They're from the same

4

Lombardo chart, three pages of clinical chemistry

5

results from the Biochemistry Department, Mr.

6

Commissioner, and they are being distributed to counsel.

7

I am sorry they were omitted. They were omitted from
the copy that we had.

8

THE COMMISSIONER: Where should they

9

belong?

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MR. LAMEK: We will give you a page

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number in the morning, Mr. Commissioner.

12

THE COMMISSIONER: All right, we will

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make it 78B and obviously Mr. Shanahan should have

14

read these. If they make any difference, Mr. Shanahan,

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you can ask any questions you like in the morning.

16

78B for these three pages.

17

--- EXHIBIT NO. 78B: Three missing pages from
Exhibit No. 78.

18

MR. LAMEK: Perhaps they could go, Mr.

19

Commissioner, between pages 97 and 98.

20

THE COMMISSIONER: Yes, all right.

21

MR. LAMEK: Thank you, Mr. Commissioner.

22

MR. ORTVED: Q So, Dr. Rowe, all I

23

want to ask you is whether, having regard to this page,

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78A which should appear between pages 38 and 39 of the

25



EE.18

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Lombardo record, whether that assists you in your
evidence concerning the state of that child's health
following her surgery?

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A. Yes, it does.

6

Q. In what way?

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A. Well, there are two main points

8

I think that come from this. I had previously, I
think in other testimony, made the point that the
baby was anemic, that there had been a note I think
on the previous page by Dr. Burns who was very
concerned about not only the state of the shunt but
the level of hemoglobin in this baby. It indicates on
the top note that there has been a transfusion
performed. Hemoglobin 12.6 grams post-transfusion.
Then the second point is that there is a note in the
middle column which is day 5, 21/12/80, it says:

16

"Stable, looks blue most of the time".

17

I think the point, particularly when crying, the point
to me there is that again there is a little more
concern in that record than appears to have been the
case in other parts of the chart about the baby's
status.

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Q. All right.

22

A. And there is also the comment I

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think that the PTT's, the partial thromboplastin times,

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which is a test to indicate the effect of heparin infusion on the blood. The PTT's are all over the place and they have obviously had a lot of trouble getting an adequate concentration of heparin for that particular baby.

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Q. All right. And then the other matter that arose out of the cross-examination of Mr. Shanahan was in relation to Baby Amber Dawson. If I could just have you refer to Exhibit No. 59, the medical record pertaining to that child. You will recall that Mr. Shanahan asked you whether or not the persistent vomiting on the part of the Dawson child might not be indicative of digoxin intoxication. Do you recall that?

A. Yes.

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Q. And I would just ask you very briefly to refer to page No. 79 of that chart, the second entry on that page where it indicates July 24th LN nursing note. Does "LN" mean all night?

A. Yes, I think so.

Q. And it indicates in the last sentence of that entry that the child vomited once when milk was forced.

A. Yes.

Q. That is the very day following admission, is that correct?

A. I am not sure. The 23rd was the day of admission, yes.

Q. And if you look at page 98 of that record where it records, the flow sheet sets out the input and output, and it would appear that this same nurse, MacIntosh, was looking after Amber Dawson up to 7:00 a.m. on July 24, 1980; correct?

A. July 24th, July 25th.

Q. She is looking after the child on July 25th but also on July 24th?

A. Yes.

Q. And then if I can ask you to look to page No. 95 of the record. Does that



Rowe
re.ex. (Ortved)

FF2

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reveal a digoxin level done on a sample taken July
24th?

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A. Yes, it does.

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Q. Of 1.9?

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A. 1.9.

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Q. Would that be within the
therapeutic range?

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A. Yes.

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Q. So, it would appear that
there was vomiting on the part of the child when
digoxin was within therapeutic ranges, according to
the test; is that right?

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A. Yes.

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Q. The only two other minor
matters I want to address with you are: Firstly,
arising out of a report of these proceedings last
Friday, August 26, in The Globe and Mail, in reference
to the mention on your part that euthanasia was
raised, the possibility on the part of your
colleagues concerning these deaths. Can you assist
me as to when that would have been raised?

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A. That would have been after
that weekend, I believe.

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Q. Which weekend are you speaking
of?

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Rowe
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FF3

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A. The weekend of March 21st-22nd.

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Q. And lastly, I think it is

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an error that may have been corrected. There was
reference in The Toronto Star on the same date to
your testimony as indicating that the Miller child
was an unquestionable death in your view. Can you
assist us as to whether that is your view?

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A. No. I think the Miller child
remains in the category of further examination by
the experts in this area of categories, particularly
pharmacology.

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MR. ORTVED: Thank you. Those are
my questions, Mr. Commissioner.

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THE COMMISSIONER: Thank you, Mr.
Ortved.

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Mr. Lamek, there is no question of
beginning today.

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MR. LAMEK: No.

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THE COMMISSIONER: I would like to
be able to promise Dr. Rowe that tomorrow is his
last possible day. In fact, I think I will promise
him that.

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THE WITNESS: Thank you, Mr.
Commissioner.

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THE COMMISSIONER: If you are not



FF4

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finished, I have to go to a meeting and if you are
not finished before 4:15, Dr. Rowe and I will both
leave!

MR. LAMEK: Very good.

THE COMMISSIONER: All right, then,
until ten o'clock.

--- whereupon the hearing was adjourned until
Thursday, the 1st day of September 1983, at
10:00 a.m.

